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the Canadian Nurse

1908

VOLUME 57 • NUMBER 9
MONTREAL
SEPTEMBER, 1961

HIGHLIGHTS

JAHODA	— Nursing as a Profession
GIRARD	— The Professional Nursing Association — and You!
THOMPSON	— A Return to Nursing
SMITH *and* BURT	— Pediatric Intensive Care Units
FLETT, McINROY *and* NIMMO	— A Respiratory Unit

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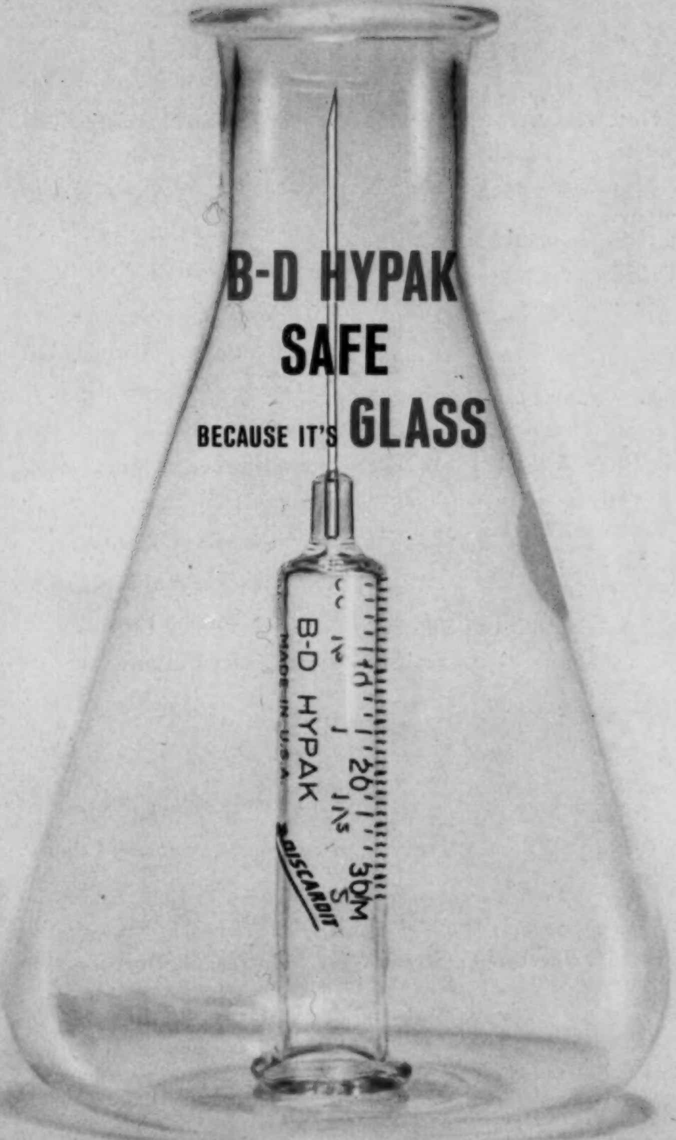
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Between Ourselves

The two addresses, delivered at the plenary session of the ICN Congress in Melbourne by Dr. Marie Jahoda and Miss Alice Girard, are featured in this issue. Both of these addresses are devoted to a discussion of the true meaning of professionalism as applied to nursing. They merit not only your careful reading but also a very considerable amount of thought and discussion.

In her explanation of what constitutes a profession, Dr. Jahoda stated: "A profession implies that the *quality of the work done* by its members *is of greater importance* in their own eyes and in the eyes of society *than the economic rewards* they earn." In your heart of hearts, do you truly believe in the emphasis that this definition places on nursing as a high calling, as distinct from a trade or a business? Can you honestly say, in the light of that statement, "I am a professional nurse"?

Last year, we listened to an interview between a reporter and a jockey that took place just before a televised horse race. The reporter said something like this to the lad: "I suppose you decided to become a jockey because you figured you could make a lot of money at it." We were really jolted when the lad replied: "No, sir. I love horses. I decided to make this my profession (profession, mark you!) because I figured that, liking horses so much, I could do a better job of riding them than some of the guys that do it just for the money they can earn." "The quality of the work done is of greater importance than the economic rewards." That young jockey, who certainly had never had the opportunities of education and inspiration that are offered to every nurse, had somehow distilled the essence of Dr. Jahoda's definition and applied it to his work. Does nursing mean that to you?

* * *

Many of you may wish to read more of the papers that were presented to the Congress members in the various sectional meetings. Only one more, the address given by your editor to the participants in the Public Relations section, will be published in our *Journal*.

The June issue of the *International Nursing Review* contains all of the addresses, including those we are publishing this month. If you do not subscribe to this valuable international publication, you may secure a copy of this edition for five shillings sterling by addressing your request to: **Miss Marjorie Wenger, Editor, International Council of Nurses, 1 Dean Trench Street, London S.W.1, England.**

* * *

A minor revolution is in the making in general hospitals across our land. It is stimulating a drastic reorganization of the services on the basis of the amount of nursing care needed by individual patients. Some of the articles in this issue discuss the development of intensive care units — part one of the progressive patient care program that is rapidly gaining favor. A correspondent wrote us regarding the reactions of her colleagues who are engaged in this kind of hospital work. You will be interested in her comments.

> My hospital friends who are working in intensive care units are much happier in their work. Some nurses are in their element doing the heavy, technical kind of nursing. They love handling all those new, complicated oxygen machines, suctions, etc. The convenience of having "all the tools" close at hand is another source of contentment and lessens frustration. On the other hand, there are nurses who sigh for the more psychological aspects of nursing which are found in the intermediate, ambulatory, and long-term care units. Why should not nurses have the satisfaction of working where their talents and interests are utilized to the best advantage? If the generalized program is overstressed in nursing and forced on everyone it usually leads to intense frustration.

* * *

Next month, the annual conference of our Editorial Advisers with the Journal Board is being held in Montreal. One of the key responsibilities of our Advisers is to keep those of us on the editorial staff informed regarding the types of articles, the topics that you our readers would like to have developed in *The Canadian Nurse*. Your suggestions are always given very serious consideration when they reach us — but! How can our Advisers bring your thinking, your wishes to us if you do not share them? Either individually or as groups through your chapters will you take the time in the

(Continued on page 804)

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Fair result only	18.2%
No help	18.2%
Anticholinergic side-effects	—

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with 10-20 mg Metaspas every 6 hours	
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Fair result only	8.0%
No help	20.0%
Anticholinergic side-effects (dryness of mouth, etc.)	16.0%

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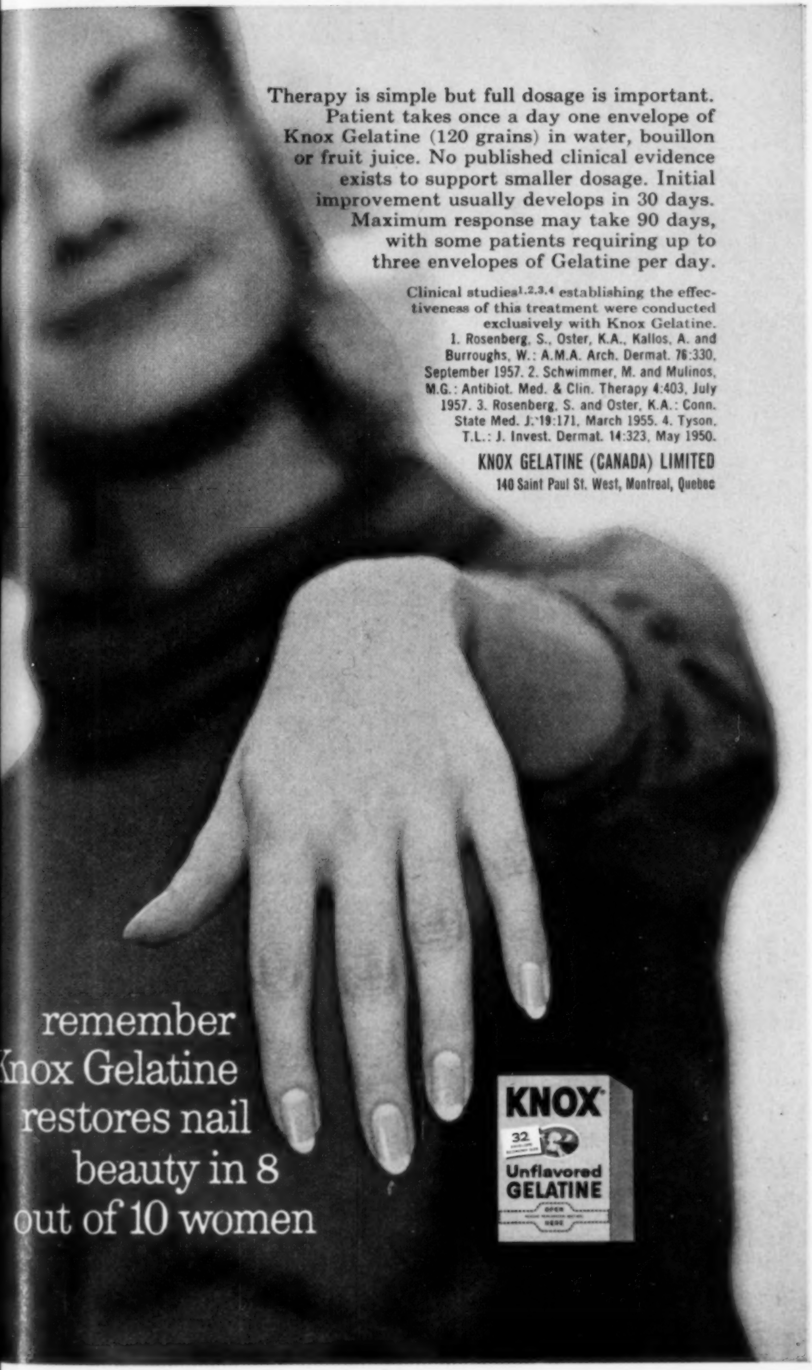
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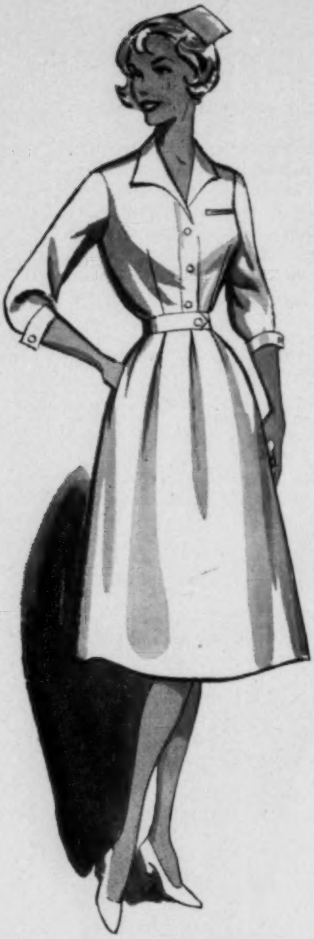

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Random Comments

Dear Editor:

Recently I purchased a White Sister nurses' uniform with maple leaf and lamp emblems imprinted on the bodice. From the advertisement in *The Canadian Nurse* I understood that these uniforms were to be worn by registered nurses only. I have seen two persons who were not working as registered nurses, wearing these uniforms.

I would be interested to know if this should be so and if not, if anything might be done about this? Thank you for your consideration.

PATRICIA ROWE, Ontario

¶*We, too, had hoped that these particular uniforms would only be sold to registered nurses. However, we realized that since they are sold in department stores the manufacturer has no control over the sales.* Ed.

Dear Editor:

I was so pleased to learn (June, 1961, p. 511) that Investors Syndicate is active in Canada.

I have been saving with them since 1933, and its the only way I could have a cent. A little each month until the first cheque came in, then I joined the diversified mutual, of the same company. A feeling of security is what we all hope for. I am so glad I kept with Investors Syndicate.

The Better Business Bureau speaks well of the company. The advertisement reads "The Man from Investors can be your best friend financially." This is so true. It is the best advice I ever followed.

ELDRETH E. MCIVOR, Maine

Dear Editor:

May I draw your attention to a statement in the article "The Provinces Report" in the May issue of *The Canadian Nurse.*

Under Alberta (3) reference is made to the pilot project on home care at Grande Prairie, Alberta. This project is sponsored by the Red Cross Society and we are anxious that the Society obtain credit for it.

HELEN M. SABIN, Alberta

Dear Editor:

The Golden Jubilee Committee would like to express sincere thanks to *The Canadian Nurse* for publishing the letter about our lost graduates.

Many nurses have told us that they saw

the notice and wrote in. The celebrations were a great success and for that, we are partly indebted to you.

It was very kind of you to help us in this way. Our sincerest thanks.

Sr. Françoise de Chantal,
Mary M. Conroy, Ontario

Dear Editor:

Would it be possible to include this notice in the "Random Comments" column in *The Canadian Nurse?*

We wish to honor the memory of Miss Jessie McKenzie who passed away December, 1960. Miss McKenzie was matron of the Royal Jubilee Hospital, Victoria from 1913 to 1927 and organized our Alumnae Association, among other worthwhile accomplishments. We are establishing a "Jessie McKenzie Memorial Fund" and wish to contact as many graduates as possible. Write to:

Mrs. Barbara Owen,
1947 Barrie Rd., Victoria, B.C.

Dear Editor:

Could you recommend a good, recent book on gerontology for nurses? I wish to increase and modernize my knowledge on this subject and would appreciate any information you can give me on publications dealing with it.

Rebecca Kingston, Ontario

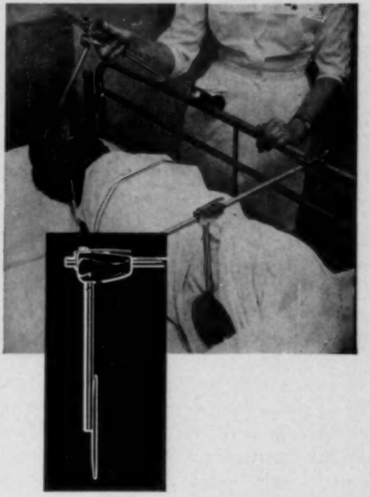
¶We have received a favorable review, which is soon to be published, of Geriatric Nursing by Kathleen Newton, C. V. Mosby Company, St. Louis, Mo. 1960, 3rd ed. Price $6.50. Ed.

Dear Editor:

Twice in my nursing career, I have applied for positions in ward administration and education. On both occasions, I was thoroughly disgusted with the business methods, yes, and even the lack of courtesy demonstrated by employers across Canada.

Let me be more specific. In each instance, I applied stating my qualifications, naming preferences and requesting information on policies. One school merely sent me application forms, asked for references to be mailed direct, but failed to indicate positions available, or to include personnel policies. Another reply came from nursing service — when I had written to the director of education. A third institution led me to believe I could obtain a position, but I waited two months for an official confirmation, and then only after a second inquiry.

I hasten to add, however that I have also received satisfactory replies, which included



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application forms, a brief job description, and a copy of personnel policies. Needless to say these are the positions I accepted.

I would like to point out that if directors of nursing expect efficiency and co-operation from their staff, they should be capable of the same.

Dedication to nursing is a fine and noble thing, but to expect a nurse to walk blindly into a new position is preposterous!

I cannot help but think these employers fail to realize how important these first impressions, gathered through correspondence, are and that they really influence the applicant. It might be very worthwhile for those schools and hospitals that are continually "short staffed" to examine their business methods. *Perplexed Nurse,* Alberta

Dear Editor:

Will you please publish the following announcement in "Random Comments?"

Attention! all graduates of Hotel Dieu Hospital, Kingston. Please send your names (single and married) and the year of your graduation by November 1, 1961, to the Alumnae Association in care of:

Mrs. William Amell,
Harrowsmith, Ont.

Dear Editor:

The Canadian Nurse is a pleasure and we read it from cover to cover, in fact we find ourselves looking forward to receiving it monthly. A diagnosis of nostalgia for Canadian nursing.

Patricia Howden, San Francisco, Calif.

(Continued from page 796)

next week or two to write to the Editorial Adviser for your own province and give her your ideas.

You don't remember who your Editorial Adviser is? That is easily corrected. Every issue carries their names and addresses on the second page immediately below the listing of the advertisers. Turn to that page right now and dash off your thoughts to the person appointed by your provincial association to be the direct liaison with us. Let us have a pile of suggestions to go through at our conference in October — Friday the 13th, to be exact.

The Chest and Heart Association is sponsoring a Health and Tuberculosis Conference to be held at the University College, Ibadan, Nigeria, March 26-31, 1962. The sixth in the series of Commonwealth Conferences, which have previously been held in London, will include lectures and panels on: Tuberculosis, the greatest tropical menace; tuberculosis and leprosy; community infection — cause and remedy; drugs — their value and limitations; the techniques of community surveys; non-pulmonary tuberculosis and travelling clinics and village hygiene.

Further details may be obtained by writing to: The Conference Secretary, The Chest and Heart Association, Tavistock House North, Tavistock Square, London, W.C. 1.

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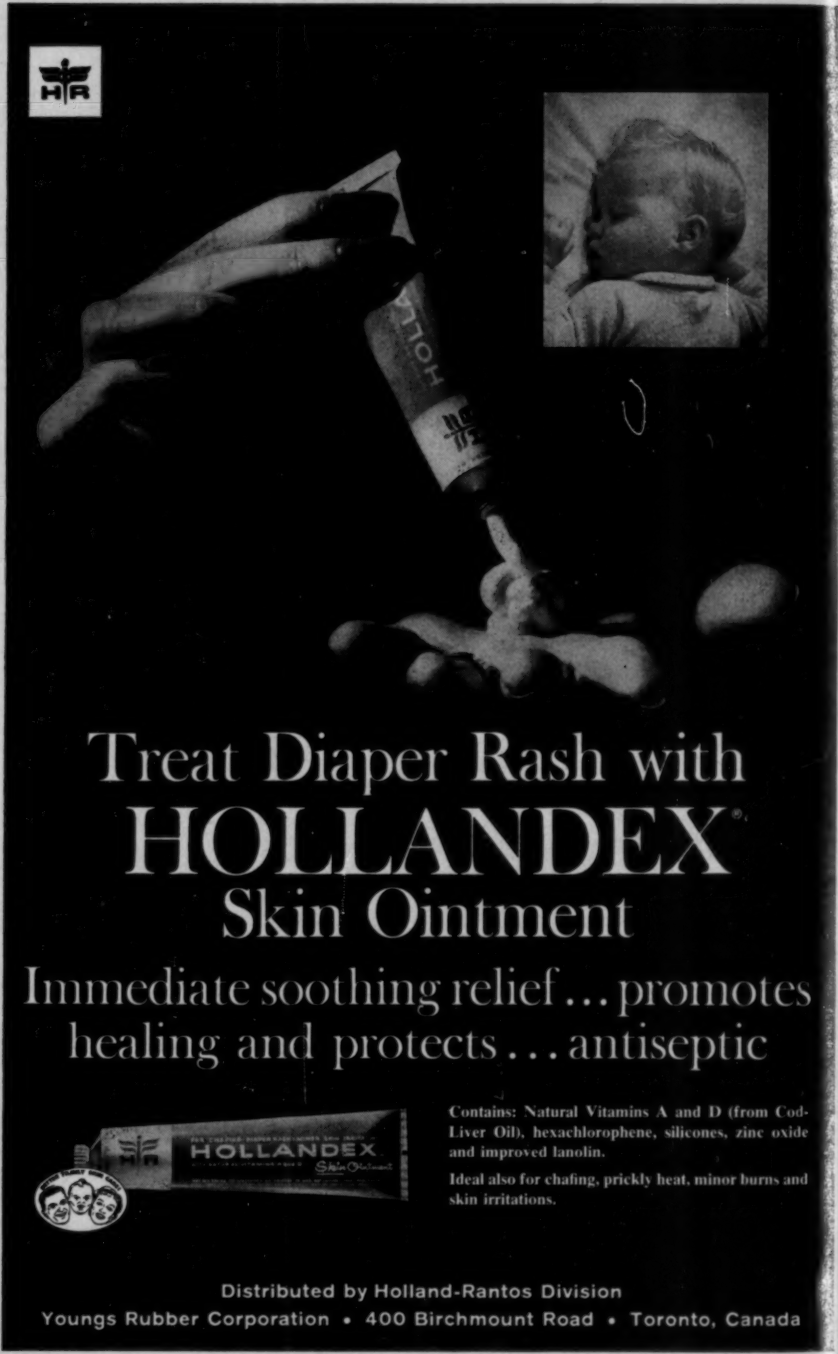

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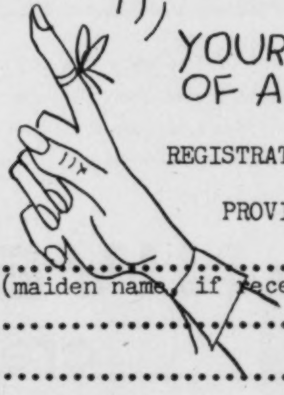

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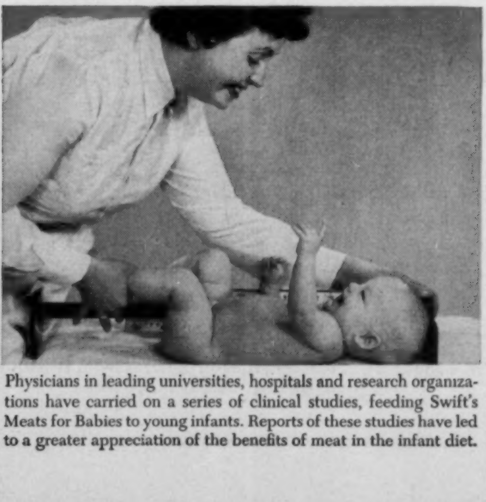

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*Bogash, R. C.; DeLa Chapelle, N.; Sowinski, R., and Downes, D.: Disposable Type Vials for Adding Medications to Large Volume Parenterals, Am. J. Hosp. Pharm. *17*:104 (Feb.) 1960.

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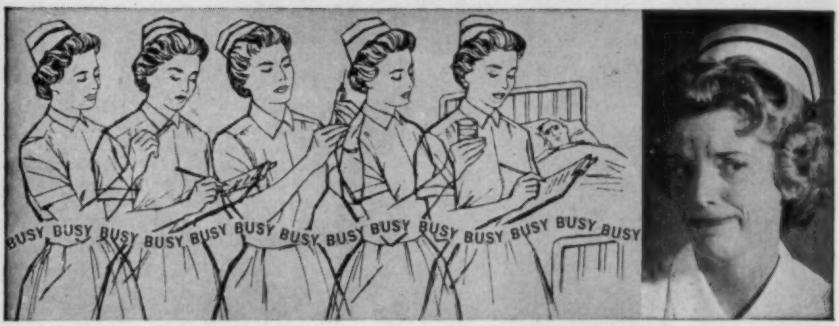
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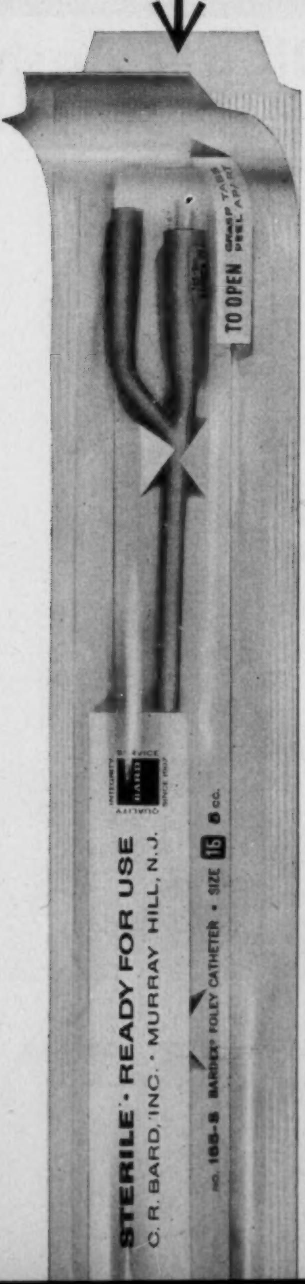
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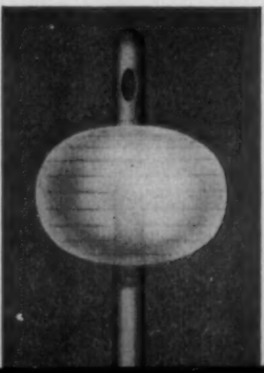

THE CANADIAN NURSE

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VOLUME 57 NUMBER 9

MONTREAL, SEPTEMBER 1961

PATIENTS COME FIRST

THE PRESENT-DAY NEED for round-the-clock nursing care for some patients has been brought about largely by advances in medical science. This statement may at first seem like a contradiction. If we think about the strides taken by medicine in the past few years we find that as medical techniques — methods of diagnosis and treatment — have become more complicated so nursing responsibilities and the knowledge necessary to carry these responsibilities have become more complex. Certain patients require what is being called intensive nursing care. It is as vigilant as the care that was given to the patient with pneumonia before the advent of anti-bacterial agents.

Certain surgical procedures that are now carried out routinely, were unheard of 15 years ago. Others, that were a novelty then and only performed by the most courageous surgeons in the largest teaching hospitals, have become an everyday occurrence. The patients who undergo such surgery are, for a few days, considered critically ill; that is, they require constant observation as a preventive measure. Their care may require many pieces of special equipment, much of it very expensive.

Advances in medical as well as surgical techniques have increased the possibility of saving the lives of many more acutely-ill medical patients. However, during the administration of certain drugs — the peripheral vasoconstrictors that are used to maintain blood pressure in severe hyptensive states, for example — the patient requires constant, intelligent observation.

When patients are scattered throughout the hospital during this acute phase of their illness, it is difficult, if not impossible, for a skilled nursing staff to observe them as closely as their condition demands. Some Canadian and American hospitals have been able to overcome this problem by grouping the acutely ill patients in one physical area. This does not necessarily imply in one large room, but rather on one nursing unit which may comprise several rooms with various numbers of beds in each. A nurse and perhaps a nursing assistant are assigned to each room, and because of the way it is equipped they do not need to leave the room in order to give constant care to their group of patients. The risk of surgical complications is decreased and the danger of delay in action in a medical emergency can be obviated.

These areas of the hospital, which are known as intensive or constant care units, may be organized to receive both medical and surgical patients, or the institution may find it more feasible to have separate units — one medical and one surgical.

Just as intensive nursing care units came into being as an extension of post-anesthetic room services, a new concept of care — progressive patient care — has developed as a result of the success of the intensive care units.

The acutely-ill period is usually of short duration. The patients are moved from the intensive care unit as soon as their condition warrants. If we accept the concept that, with the exception of terminal illness, the hospital assists the patient in a progression towards improved health, then the idea of progressive patient care is a reasonable one.

Several American hospitals have completely reorganized their facilities, services and staff around the medical and nursing needs of the patient. Patterns vary from one institution to another, but in general, such a program consists of five elements:

Intensive care unit, specially staffed and equipped to care for critically ill patients; whether medical or surgical;

Intermediate care unit, for patients requiring a moderate amount of nursing care;

Self-care unit, for patients who are physically self-sufficient but still require a great deal of restorative care such as teaching and rehabilitation, or who were admitted to the hospital for diagnostic work;

Long-term care unit, for patients needing prolonged care or rehabilitative assistance, requiring the services of the hospital;

Home-care program that is hospital based.*

From interview studies that have been carried out in hospitals where progressive patient care is in operation, patient satisfaction is very high. One might expect that patients would dislike being transferred from one unit to another. Instead, the very fact of the progression is evident to the patients as well as to the staff. The effect of being "promoted" may be almost magical.

But what of the general nursing staff? Nurses, like people in any profession that offers a wide variety of roles and activities, have particular preferences. As there are those who prefer to work in an emergency room, with all that that type of service entails, so there are those who prefer to nurse the long-term patient or the ambulant patient. This new form of organization of the nursing services, permits staffing of the units according to the nurses' preferences. Where this practice has been instituted, statistics show that the turnover and instability rates are considerably reduced.** An increase in job satisfaction will inevitably be reflected in a higher quality of care.

The private nurse, too, has been affected by medical advances in procedures, techniques and equipment. Because she is not employed by the hospital and therefore cannot avail herself of inservice education programs, including lecture and demonstration of new methods, techniques and theory, she may feel extremely insecure. The nurses in intensive care units are specially trained for this particular type of nursing and the need for private nurses for care of the critically ill has largely been eliminated. There are, and probably always will be, patients on the other units who desire private nurses. In the past, it has not necessarily been the acutely ill patient who has requested private nurses; many long-term patients have been successfully rehabilitated almost solely through the efforts of individuals in this group who, through understanding, warmth and patience have given that "extra" that is essential to the patient's recovery.

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*Faye G. Abdellah and E. Josephine Strachan: Progressive Patient Care, *A.J.N.* 59: 649-655. (May 1959).

**Eugene Levine and Stuart Wright: New ways to measure personnel turnover in hospitals, *Hospitals* 31:38-42, (Aug. 1957).

Progressive patient care is only one method of trying to meet the nursing needs of the sick. It may not be the best method, but as long as nurses continue to be imaginative, creative and then, courageous in a new venture, nursing at the service of patients will continue to be the practitioner's primary goal.

Pamela E. Poole

NURSING AS A PROFESSION

Marie Jahoda, ph.d.

This address was given at a plenary session of the ICN Congress in Melbourne, 1961.

When I first began to collect ideas on the profession of nursing, I was struck — as, I believe, every newcomer to the field must be — by the enormous amount of literature and research on the subject. For a while, I even entertained the idea that the ICN in its tremendous zest for education had asked me to address you because the preparation for this speech would provide an educational experience of considerable impact for at least one social scientist. It did indeed! However, I came to realize that this was an unintended byproduct of conference planning. An organization as devoted as the ICN to the idea of service to the profession, so permeated by a sense of responsibility to its members, must obviously have had other purposes in mind. There is nothing that I can tell you about nursing from practical experience. So the only possible purpose in having an outsider to the profession look at it on an occasion like this is to obtain a different perspective of a situation of which you know all the salient facts. For if there is anything new to be said about nursing —and I am not sure that there is — it must come from you as you apply different modes of looking and thinking to matters which have become commonplace to you in your professional life.

Let me begin by explaining in a few general terms the particular perspective which I can bring to your problems, that is the perspective of social psychology. Social psychology like every other branch of science, is a deliberate effort to simplify the innumerable unique events in which we take part in our existence on this earth, in such a way that we can think about them, understand them and occasionally perhaps, even predict them; in particular "social psychology is an attempt to understand and explain how the thought, feeling and behavior of individuals are influenced by the actual, imagined or implied presence of other human beings."[1] If you wish to think of an example that gives concrete meaning to this definition of social psychology, think of the influences on a nurse's thoughts, feelings and behavior: They stem in part from the people among whom she actually works, be it her seniors, a colleague, a doctor, or a patient; in part from the people whom she can imagine while going about her job, be it her family, her teachers, or a friend; and in part from her membership in the profession which implies nurses all over the world, now or in previous generations, who have established the profession. It is, in particular, this last aspect of social psychology, the influences stemming from social institutions such as a profession, with which I propose to deal.

To be able to create institutions, to be shaped by them in one's conduct and to change them in the light of experience is a uniquely human quality. The social and psychological environment within which we live makes it possible for us not only to rely on

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Dr. Jahoda, a social psychologist, is Research Fellow at Brunel College of Technology, London, England.

ourselves but also to profit from the achievements of all previous generations whose experiences are condensed in the institutions, values and ideas which guide us. Without the great protection that stems from past inventions of ways of dealing with the demands of daily life, we would be in the position of primitive man, if not of animals, overcome by fear, rage, passion or self-destructive megalomania. The eminent Canadian psychologist, D. O. Hebb,[2] has actually expressed the idea that man's emotional stability is not inherently greater than that of higher animals. According to him it is the creation of a protective environment which makes civilized *human* life possible. If you accept Hebb's idea that a function of the environment is to protect some degree of emotional stability, then we have an implicit yardstick for appraising the adequacy of professional organizations: To what extent do they fulfil this basic function of man-made environment? This is the central question to which I want to direct my remarks.

But, before we can think about it in relation to nursing as a profession, it will be appropriate to make clear what is meant by a profession. This will lead us to a discussion of the essence of professional activity, that is, the relation of the professional person to his clients or patients, and to an inquiry into the social mechanisms a profession can use in shaping the individual's relation to them. You will, I hope, bear with me if I use as examples not only nursing but other professions too, and if I leave the answer to the basic question of how well the nursing profession protects the emotional stability of nurses and patients to yourselves. For not only will this answer inevitably vary with conditions in different countries, but it will have to be given again and again as the world around us and the profession itself develops. In a century whose outstanding feature is the rapidity of social and technological change, no human institution can afford to rest on its laurels, however well deserved.

What is a profession?

In everyday life the idea of a profession presents no particular difficulty. Everybody thinks immediately of the traditional professions such as law, medicine, teaching or the church. While nobody will dispute the professional status of these occupations, traditional consensus is not a good enough basis for discourse, particularly when one is searching for a means of deciding whether some other occupations, such as nursing, for example, can legitimately be regarded as a profession. Perhaps a search for common elements in the traditional professions will help. They are not just an organized group of persons who earn their living in the same fashion; they are different from an organization of metalworkers or street cleaners or business men, even though they, as well as these other organizations, are rightly concerned with the economic welfare of their members. The traditional professions have other distinctive features; perhaps most outstanding among them is that their members possess specialized knowledge which is acquired through formal education beyond the schooling that is common to all members of a nation as prescribed by the law of the land. Specialized knowledge acquired in this manner and applied in one's way of making a living is a necessary but not yet a sufficient way of describing the essence of a profession. After all, a skilled worker who acquires his specialized knowledge in years of apprenticeship after school and who can do things neither you nor I can do, is not regarded as a professional person; nor are business executives or laboratory technicians necessarily so classified. There is in the organization of professional persons another element of a more psychological nature involving a common factor in the attitude of their members to their work which seems to me to be the very essence of a profession. *A profession implies that the quality of the work done by its members is of greater importance in their own eyes and in the eyes of society than the economic rewards they earn.* As R. H. Tawney[3] has said, a profession is "a body of men"—and women, one would like to add—

> who carry on their work in accordance with rules deseigned to enforce certain standards both for the protection of its members and for the better service of the public . . . (Its) essence is that,

> though men enter it for the sake of livelihood, the measure of their success is the service which they perform, not the gain which they amass. They may, as in the case of a successful doctor, grow rich; but the meaning of their profession, both for themselves and for the public, is not that they make money but that they make health, or safety, or knowledge, or good government or good law.

There is implicit in Tawney's concept of a profession an element of great importance: for an occupational group to become a profession is an act of *voluntary decision by its members* — voluntary at least for the first generation which adopts professional standards — provided that the occupation is such that it contributes services or work which are based on special knowledge. There is no social law, and certainly no natural law, from which it follows that nurses must be professionals. But a few generations ago some nurses decided by voluntary action to become a profession. And, that the decision is in line with the attitude to work of the current generation is demonstrated by the ever-increasing number of members in professional nursing organizations all over the world. Notwithstanding the voluntary action which stands at the beginning of a modern profession, its consequences are generally legal recognition. The voluntary decision of the past becomes the compulsion of the present. It would require great courage and massive evidence of its desirability for any profession to reverse the decision totally or partially.

The essence of a profession, then, is that it is an organization of an occupational group based on the application of special knowledge, which establishes its own rules and standards for the protection of the public and the professionals. Its emphasis is on the quality of performance rather than on the self-interest of its members. It comes about by voluntary collective action which is transformed into the tenets of the professional organization; these, in turn, become binding on the members.

One may well ask why the establishment of protective devices and professional standards is such an essential ingredient of a profession. I believe that this has to do with the specialized knowledge which professional people apply in the service of others who have to take it on credit, so to speak, because they are not in a position to form a rational judgment on the quality of the service rendered even though their own well-being depends on this quality. This kind of relation between the professional expert and the dependent layman is inevitably full of strains and of temptations to misuse the power conveyed by special knowledge. Protection and standards are essential to reduce the strain on the professional and to safeguard the lay person.

The point is of importance in relation to the different types of services which are rendered to the sick; not all of them are based on knowledge which the lay person is unable to judge. The idea of grading nursing into professional and sub-professional occupations is closely linked to this point. But more of this later.

The adherence to professional standards is not only a question of an individual's abilities and integrity, even though these are tremendously important; in addition, there are the social and economic conditions under which a profession operates and which may help or hinder adherents to standards, as may the requirements of the situation within which the professional activity is usually carried out.

Take as an example of social conditions affecting the adherence to professional standards the distinction between working among colleagues or working alone. Some professional people perform their work in isolation. Classical examples are the psychoanalyst or the librarian, but the work of the public health nurse and sometimes of the industrial nurse comes fairly close to it. Others, like engineers or hospital nurses, are as a rule surrounded by colleagues. The psychological difference between these two working situations is enormous. The isolated professional carries the full burden of responsibility for his actions; he cannot pass the buck. On the other hand, he is not subjected to criticism and control. If he lowers or modifies his professional standards under the stress of a particular case, this may not only remain undiscovered by the outside world but he himself may not be aware of it. In the interest of protecting the public, the functioning of the isolated professional needs special safeguards. Those who work surrounded by colleagues on the other hand, are permanently open to criticism by qualified colleagues; the *public* is well protected. But what about the professional person? *Carrying responsibility is the essence of professionalism.* If tasks are so organized that individuals do not feel that they are responsible for their actions, they are deprived of a major satisfaction in their work, and many will consequently lower their standards. From industry come many complaints that engineers often act not as professional people but as job holders who rely on somebody else to make sure that their work meets the standards and who show little initiative. It may be only the other side of this coin that many engineers forsake the exercise of their technical skill in mid-career and move into managerial or business positions; what is more, they apparently take pride in that fact, in contrast to doctors whose individual responsibility is not so diluted and who look askance at a doctor who has become successful in a non-medical field.[4] Whether or not the desertion of one's profession is a direct consequence of diluted responsibilities, when professionals work as employees among colleagues, measures for the protection of their professional pride are probably in place.

Economic conditions, too, influence the adherence to professional standards. Professional work can be carried out in a buyer's or a seller's market. In some professions there are too many candidates for the available number of senior positions, so that promotion is dependent upon stepping into a dead man's shoes.

Such a situation threatens the solidarity among professional people who are driven into fierce competition for the scarce top positions. The bitterness of academic politics, such as C. P. Snow described in his novel *The Masters,* is one possible result of it. Other professions, undermanned for a time, have been so coaxed by society that the influx into them threatens to create over-production. The American Psychological Association is a case in point: in 1920 there were 3.7 psychologists per million of U.S. inhabitants; for 1960 the figure is estimated conservatively as 106 psychologists per million.

The nurses of the world are in a different position. Though the supply has grown enormously in recent decades, and much more so than the population, the demand for their services has grown even more.[5] In many countries the number of vacancies considerably exceeds the number of professional nurses, while in some industrially less developed countries available nurses cannot find employment, even though their services are urgently needed, because of lack of money. As you know, the shortages are particularly severe for senior positions and for psychiatric nursing. Where such shortages exist, the burden on the profession becomes considerable, for it is clear that the quickest way to remedy it is to lower the qualifications. Many professions, but particularly young professions such as nursing, passionately resist such suggestions which they feel threaten their hard-won professional status. Yet, so pressing is the shortage that most extraordinary means are taken by society to deal with the situation. A few months ago I came across the following newspaper item:

> "Electronic Nurse" in U.S.
> Constant Check on Gravely Ill.
> New York, Wednesday.
>
> Electronic machines began today to replace nurses in caring for patients at the Roosevelt Hospital, New York. The equipment, which provides continuous monitoring of the condition of those who are gravely ill, has been installed in a 17-bed special-care ward. It checks pulse and respiration rates and temperatures and will take electrocardiograms and electroencephalograms.
>
> Hospital officials said that the new ward was a "child of the nursing shortage."

And yet, before we yield to the understandable sense of horror at the response to shortage, it is well to remember that another profession in which shortage is also world-wide has to face a similar situation: the profession of teachers on the level of elementary schools. Skinner, a Harvard psychologist, has developed teaching machines which can instruct a child in the basic rote learning that industrialized societies require, that is spelling and simple arithmetic. The teaching profession greeted his invention with horror and fear of being made redundant. It would be possible, however, to look at the device as a way of freeing the teacher for his truly professional activity of educating for which no machine can substitute (at least, not yet). I do no know enough about the electronic nurse to be able to judge it. I have told you about it only to emphasize the point that if you do not solve the problems of shortage, others will—for better or worse.

However, social and economic conditions of professional work, notwithstanding their importance, are only peripheral to the actual work situation. Whatever problems they raise must be tackled in the light of the central issue of every profession: the actual performance of the task in relation to the person to whom a service is rendered. All organizational and institutional provisions must be judged, finally, in their impact on this central theme.

The Professional Situation

I started off by saying that one major function of the environment is to protect emotional stability; in terms of your profession the working situation should protect the emotional stability of patient and nurse. Now there is hardly another profession in which such protection is more urgently needed. Even though nursing is now a very diversified profession, the great majority of nurses the world over are dealing with the sick. The recent ILO survey[5] based on returns from some 40 countries, states that in 1956-57, about 72 per cent of the professional nurses were engaged in hospital nursing, 6 per cent in public health service, 3 per cent in domiciliary work, almost 3 per cent in occupational health nursing and 16 per cent in other fields. In view of the training which nurses receive, the experience of working with the sick is nearly universal, particularly in the early stages of a nursing career. This universality of hospital experience entitles one to take it as the prototype of the nurse's professional situation.

There exist many technical job analyses of what a hospital nurse actually does. Her activities range from taking care of equipment through basic nursing of patients to highly skilled technical tasks such as artificial feeding, and include a fair amount of administrative work. At the lower level of skill the nurse's job overlaps with that of domestic staff, at the higher level with that of the doctor. This overlap is inevitable; it accounts to a large extent for the status stresses in hospitals.[6] Nursing is not the only profession which has to define its status on an in-between level. Architecture, equally young as a profession and equally old as a human activity, overlaps on the one extreme with the builder, on the other with the creative artist. For the nurse, these status problems are further enhanced by the peculiar position of the patient whose illness deprives him of the normal duties and privileges of an adult and makes him utterly dependent on the professional staff.[7] It is the nurse who is constantly on duty and not just the doctor who pays periodic visits, who must maintain vis-à-vis the patient the aura of competence and authority, even though she must realize at the same time that while she has full responsibility in the doctor's absence she does not have the authority of his profession. "In many situations of this kind — that is, wherever responsibility is felt to be greater than the authority of a job — there is considerable insecurity of those who must bear the burden of such disproportionate responsibility."[6] But more powerful and more universal than the status problems of a nurse in the hospital situation are the emotional stresses inherent in dealing with illness and injury. They are, I am sure, familiar to you. Let me recall them to you in the words of Miss Menzies who has recently conducted a study of a teaching hospital.[8]

> Nurses are in constant contact with people who are physically ill or injured, often seriously. The recovery of patients is not certain and will not always be complete. Nursing patients who have incurable diseases is one of the nurse's most distressing tasks. Nurses are confronted with the threat and the reality of suffering and death as few lay people are. Their work involves carrying out tasks which, by ordinary standards, are distasteful, disgusting, and frightening.

The experience of suffering and death are alien to no human being.

Those of us who are not confronted with these matters in our daily work as well as you who are, must realize that these experiences touch the very root of our existence, that they reactivate our earliest fears and anxieties, passions and agressions from which the daily routine of normal adult life protects us to varying degrees. For the hospital nurse it as her daily work which mobilizes these "strong and mixed feelings . . . : pity, compassion, and love; guilt and anxiety; hatred and resentment of the patients who arouse these strong feelings; envy of the care given to the patient."[8] It is not only the intimate physical contact with death and disease that threatens the nurse's equilibrium. Inevitably, the patients and their relatives find themselves under psychological stress of a kind that brings to the fore otherwise hidden anxieties. Not only the body but also the emotional turmoil of suffering people is exposed to the nurse; whether what she sees arouses tenderness or repulsion in her, she is expected to ignore her feelings.

There are basically three different ways of dealing with intense feelings, and ignoring is not one of them. One is to yield to them; the second, to defend against them; the third to face them directly, work through them and reduce their power. The first one is, I believe, what nurses regard as unprofessional conduct. But since nurses are only human it must occasionally happen that they give their love to one patient and deny it to another; that hatred and envy induce them to use their power over a patient for their own gratification; that they go away into a corner to cry their eyes out over the misery they face.

It is the second way which is probably most frequent: the defence against emotion. Nurses, like other people, can repress or deny their feelings; they can project them on to others; they can dehumanize the patient and regard him as a case of a disease rather than as a human being, thus remaining efficient in the narrow, technical sense but hard and callous as persons, unsuited for the humanitarian task of their professional work. Or they can, as in the bad old days of nursing a century ago, drown their problems in gin!

The third way is probably the most difficult of all: to admit and confront one's emotions, to identify the aspects which stem from unresolved conflicts and experiences in ourselves, to recognize that the nursing task makes it possible to sublimate them rather than to enter into the heart-breaking reliving of earlier emotional crises. Psychoanalytic theory and practice suggest that the root of these passionate emotions lies in events in infancy and childhood. Because of this hidden origin, good intentions are certainly not enough to enable a person to deal with intense feelings; not even a flash of insight which reveals in one particular case why one patient is disturbing to a nurse will do. The process of working through one's emotions and their origins is long drawn out, cumbersome and often painful. There are very few nurses, or others for that matter, who have the ability and energy to accomplish this without help.

These are the ways of individuals in dealing with the strains of their work situation. Where professional organizations are non-existent or underdeveloped, the goodness of the nursing task will be at the mercy of the strength or weakness of the individual nurse. But a major function of a profession is to "minimize the need for . . . improvising private adjustments to conflict situations."[9] How the profession can deal with this is the problem to which I now turn.

Social Mechanisms of Professions

Every profession develops techniques of its own to help its members deal with the intrinsic difficulties of their task; I cannot here describe all the actual and potential ways that your profession has at its disposal. Let me limit myself to a few which bear directly on my central theme — the emotional protection of nurse and patient. Social mechanisms are inventions whose consequences are not always foreseeable; one needs to be alert to the fact that even those which were conceived with the best intentions can have some undesirable by-products.

Foremost among the mechanisms used by all professions is the effort to spell out in detail the ideal of service, in the case of nursing a deeply altruistic ideal. No better summary of this ideal could be presented than to repeat to you the great watchwords which the presidents of your organization have given you over the years: Work, Courage, Life, Aspiration, Concord, Loyalty, Faith, Responsibility and Wisdom. These are great words; but let me confess that when I first heard them, and particularly when I realized that I had to speak under the theme of the last, I felt faint! I recovered only when I realized that the nursing profession recognizes that while the appeal to ideals of service is one crucial way through which the profession can establish standards and help its members face the task of their daily work, it must be only one among many. The great words in isolation might make the cynics sneer and the sincere despair. However, your Congress is evidence of your permanent concern with the more mundane mechanisms the profession uses: the problem of nursing education which, as far as I can see, has never been absent from your deliberations; the concern with the economic welfare of the members of the profession and with their general working conditions, and the communications within the profession and between it and other professions and the community at large.

There is a profession, very different from your own, which in some parts of the United States had recently to pay the price of being equipped with a great ideal but deprived of the ways and means to carry it out. I am talking of the librarians, one of whose central tasks is book selection. It is in their performance of this central task that some of them have been criticized in the last decade during the difficult years of suspicion and mistrust in the States. The library schools equip their students with the magic word "balance" to help them in selecting books. But the magic of a balanced collection does not stand the test of professional practice. In a recent study of librarians[10] there was evidence to show that a great word without mechanisms of implementation does not help the profession. One librarian when asked how she achieved balance said "Balance just happens," and another called balance "a semantic absurdity. What it boils down to is that you provide as much as you can of what anybody wants."

For the librarians as well as for the nurses it is probably true to say that *unless great principles are transformed into techniques and procedures deliberately constructed to express them, principles will lose their power.*

But there are other mechanisms to support them. Traditionally, one of the most compelling ways to ensure adherence to standards is drill and discipline, as the military profession has realized throughout the centuries. It is, perhaps, not only the historical accident that Florence Nightingale had to establish her nursing service under military command in the Crimean war which induced the profession to rely heavily on discipline. There is, after all, another important influence on the development of nursing as a profession: the religious orders which undertook the care of the sick are on a level with military organizations in the sternness of their discipline. The tradition of discipline, not only in the work but also in the prescribed way of life of nurses, has not remained unquestioned in modern times. Nobody actually disputes the need for discipline in a profession which inevitably challenges the ordinary degree of stability acquired by most people in the process of growing up and which threatens to unleash untamed emotions. But the externally imposed discipline which, in a sense, was intended as a protective measure has two undesirable consequences as Miss Menzies[8] has shown in her study. Where every movement and gesture is prescribed as in a ritual, responsible initiative must necessarily be curtailed. And where the conditions of life in a profession are in sharp contrast to the spirit of the time and the way of life in other professions, young people will look to different work or rebel during training and leave the profession. Both these points will need to be considered later on. Here the question arises whether there are other means than ritual and regulation to ensure the discipline necessary for nursing.

There is some preliminary evidence to suggest that where nurses are trained with the full status and freedom of students rather than under the strict discipline of a hospital employee, their attitude of nursing is very different at the end of their training.

Miss Genevieve Meyer[11] compared the working attitude of nursing students in their last year of training "of a collegiate school with a new approach to patient care and that of a more traditional hospital program." She found that aspiring nurses at the outset of their training greatly preferred working with patients to working with doctors, working alone, with other nurses or with aides. The group of collegiate nurses at the end of their training had even increased their preference for working with patients; the hospital seniors, however, had changed. They would much rather work with a doctor than take care of patients, and were altogether less positive in their attitude to nursing than the first-year students. Unfortunately, the study does not describe in sufficient detail what other differences existed in the two types of training, apart from the different status of the students.

However, the shortage of nurses has compelled many hospitals to offer less strictly regulated living conditions to nurses; and as a result some of them have discovered that full freedom in private life as it is enjoyed by nurses who are not living in, can attract many to return to the profession which they had given up because they wanted more freedom.

To be sure, the assumption that it is the hard life and the strict external discipline which alone can strengthen the character of a nurse for her task is gradually dying out. Great progress has been made during the last decades in improving the living and working conditions of nurses.[12] Working hours have been reduced, salaries increased, the curriculum of training has been improved, and nurses in training enjoy a greater measure of student status than they had ever before, even though a recent study disclosed that the maximum time available for sitting down for a junior nursing student during eight hours of ward duty in one very advanced country was 20 minutes! It is on the human and psychological side that inventiveness has perhaps not gone far enough to protect the nurse and thus, indirectly, the patient.

Let me take as an example one of the most stressful, even though potentially one of the most rewarding of nursing tasks, psychiatric nursing. You all know how serious the shortage of personnel is in this field. In the United States where almost half the hospital beds are occupied by mental patients, less than 5 per cent of hospital nurses are attracted to psychiatric nursing.[13] So strong is the stress of the task that nearly 40 per cent of psychiatric nurses, admitted in research interviews that they had considered leaving this field at one time or another;[14] the American Nurses' Association[15] reported that while there was 1 nurse to every 3 beds in general hospitals, there was only 1 nurse to every 53 beds in psychiatric hospitals, a serious shortage even if one takes into consideration that there is less physical helplessness in mental hospitals, and thus no need for the same number of nurses as in other hospitals.

External discipline alone will obviously not deal with such a situation. However, an encouraging effort has been made in at least one psychiatric hospital to help nurses in the acquisition of internal discipline by dealing with the great anxieties which intimate and continuous contact with mental patients arouse in so many people.[16] The nurses were encouraged to discuss with properly qualified persons, individually and in groups, the nature of the feelings aroused by the patients' behavior to them which ran the whole gamut from utter dependency to sexual advances to acts of violence. Being able to admit that they felt disgusted or frightened or tender, as the case may be, to one or the other of the patients, that they were influenced by what the rest of the staff thought of them, or by less easily identifiable anxieties, helped these nurses to achieve some mastery over their own emotions which had previously compelled them to close their eyes and deny their help to the patient's deepest needs. One wonders whether similar techniques may not also be profitable in dealing with the ordinary hospital nurse's emotional strain. If this sounds like a soft option, measured against the tremendous achievements of a Florence Nightingale under the conditions of Scutari, it is perhaps well to remember that this most tender nurse was also the demoniacal woman who could berate without mercy her great friend Sidney Spencer, the Secretary for War, in his dying days as a weakling who had deserted her cause.[17] The heroes and heroines of a profession are not necessarily the best guide for developing mechanisms of professional conduct for us who are human, not superhuman.

Another of the social mechanisms used by the profession to safeguard the nurses' feelings and prevent their over-involvement with individual patients is the assignment of tasks which make it necessary to go from one patient to the next in quick succession without having time to concentrate on the needs of an individual human being *in toto.* However, recent trends are against this defensive measure, in the interest of the patient who needs to be helped as a person, not as a conglomeration of unrelated needs. The switch is now often made to patient assignment and team nursing achieves a better protection of the sick, but it removes a protection from the nurse. Here as elsewhere the situation requires the search for an optimal solution for both the profession and the patient, not a maximal protection of either at the expense of the other. It is well possible that the close collaboration between nurses required by team nursing will function as a protective device. I do not know enough about it to be able to say that this is the case.

While many of the emotional strains in nursing are often not readily admitted, one of them is the fear of making mistakes which might be fatal. A mistake in the administration of drugs and treatments as much as the failure to observe newly emerging symptoms indicating a deterioration in the state of a patient are ever-present possibilities in the daily work of a hospital nurse. In the hospital studied by Miss Menzies the organization of the nursing service attempted to spare the staff this anxiety by minimizing the number and variety of responsible decisions which a nurse could make. The student nurses were trained to perform their duties in a ritualistic manner which did not permit the slightest deviation. "As a corollary, the student nurse is actively discouraged from using her own discretion and initiative to plan her work realistically in relation to the objective situation, e.g., at times of crisis to discriminate between tasks in the grounds of urgency or relative importance and to act accordingly."[8] In consequence, student nurses, and perhaps occasionally, fully professionally trained nurses too, find themselves in a curious dilemma. All their verbal training during instruction hammers into them the heavy responsibility of a nurse; much of their work, however, is organized in such a manner that responsible action becomes impossible.

The very complicated dilemma of wanting to instill a sense of responsibility into the student nurse while, *de facto,* eliminating all chances for decision-making has probably much to do with the great wastage of students in training. Some people have suggested that it is not only the unsuitable students whose personality or intelligence is not good enough for the training but also the highly intelligent girls, keen on taking responsibilities, who drop out.

This suggests that the profession engages to some extent in overprotection which may deter at least some otherwise suitable students. I am not aware of any detailed account of the type of student who gives up during training, but there can be no doubt that many girls choose a nursing career out of idealism and a strong wish to carry responsibility, even though — as one study suggests[18] — it is for many a second-best choice; they really wanted to become doctors, but lacked either finances or educational qualifications to do so. It is this type of girl for whom the frustration of being deprived of responsibility is probably most difficult to take. In any case, the figures of wastage during training are one indication that the social mechanisms developed by the profession need reconsideration. An American study[19] which gives the nation-wide average of wastage as 33 per cent found it to be 80 per cent for 20 training schools, and 100 per cent for 3 training schools. What is even more startling is the fact that only 7 per cent of these girls left to get married; about 10 per cent failed in their classwork. The large remainder either disliked the work or were considered unsuited for it.

Of course, it is possible to look at wastage from another point of view. What would happen to the nursing profession if all wastage in training were eliminated? Would not the market be flooded with competent fully trained nurses who might then not find jobs or at least not jobs up to the level of their competence? It has been suggested[8] that the wastage of student nurses is a "device to maintain the balance between staff of different levels of skill while all are at a high personal level." After all, there are very few hospitals in which the large majority of nursing tasks are carried out by fully trained professional people. Yet, on the other hand, the development of medical science makes more and more demands on the intelligence, skills and knowledge of the professionally trained nurse. The dilemma was recognized several years ago by Miss Lindstrom,[20] when she said: "The tendency of the nursing profession has for years been to charge itself with constantly increasing duties, without, in general, being willing to delegate any of its previous obligations to others." Perhaps this tendency, too, is a social mechanism with the good purpose of increasing the status of the profession and the unintended consequence of adding to the strain on its members. To the outsider to your great profession it appears that its unity — hard fought for in the past — may no longer present an adequate solution to its professional problems. Just as other professions have become dependent on groups of specialized technicians of subprofessional status, nursing may increasingly have to learn to delegate to nursing technicians in order to fill better its own professional aims. A separate training, with lesser entrance qualifications and of shorter duration, would attract different types of candidates. On the other hand, it might make it possible to organize nursing in such a manner that the professional nurse can carry her full share of responsibility in the medical team. May I remind you at this moment of the voluntary act in becoming a profession and the possibility of voluntary action for redefining membership in the profession. Not all work with patients requires professional status; some of it requires the highest professional standards — in the psychological field perhaps, even more than is currently incorporated in any training syllabus. You may want to consider the organizational consequences of this situation.

Conclusion

Let me once more revert to my central theme: does the nursing profession adequately protect its members and the needs of patients and the community? You can see from what I have said that I have no ready-made answer to that question. By virtue of claiming professional status you are committed both the service and to self-protection. But, as the profession is constituted today, you are facing grave problems in both respects which may yield only to radical thought and radical action. This challenge, I am sure, will not discourage you. For to search for the best balance between these twin tasks of professional organization and to adjust it to the ever-changing needs of the community is in keeping not only with the great ideals of nursing, it is also the most human and most humane goal any profession can embrace.

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A Message from the New ICN President

I am happy to take the opportunity of this post-Congress News Letter to send to the members of the ICN my first message as their president.

I wish to say how glad I am to have met some of you in Melbourne. I trust that you are now safely home, back at work, and that inspiration from the Congress is helping you to face your daily difficulties. To those who did not have the privilege of attending the Congress, I wish to say that I do hope they feel strongly, nevertheless, that they belong to the large family of the nurses of the world.

One of the things that always strikes me when attending an international congress or when meeting nurses from other countries is that in spite of differences due to language, traditions, local customs, we have many points in common, so many that they mean much more than the differences.

The reason for this is that the centre of all our activities is mankind — man with his suffering and his problems. In choosing to serve, to relieve, to help those of every age or condition, it is important that in the world of today, where distances do not count, we should strive to make our common points stronger, so that the differences may become less and may be gradually overcome.

This is true for all, but nurses, because of their profession, should give the lead. Mrs. Bedford Fenwick had the vision of this when she founded the International Council of Nurses 62 years ago. It belongs to each individual nurse to work through her national association towards this goal — a goal that is well worth our efforts.

I wish you courage and wisdom to undertake this task.

Alice Clamageran,
President, ICN

Food particles left in the mouth after eating can develop into destructive acid that causes dental caries. The teeth should be brushed *immediately* after eating, or the mouth rinsed with water.

The man at the next desk, about to enter the hospital, says he doesn't fear the needle, the knife, nor the surgeon's bill, but he flinches at the thought of the funny get-well cards.

The Professional Nursing Association – and You!

Alice Girard, M.A.

This address was given at a plenary session of the ICN Congress in Melbourne, 1961.

THE PRESENCE of so many nurses from so many areas of the world, here in Melbourne, is, first of all, an impressive human spectacle and secondly, a pleasing experience. It is also a normal event, quite understandable in terms of human relations. From time immemorial, human beings have felt a strong, basic need to associate together. This need is rooted in human nature itself. Very early in the history of the human race, people became aware of the mutual or reciprocal effects which human beings in association can exert upon one another. From this premise it was but a short step to the conclusion that, given unity of purpose and harmony of direction, these effects could make mutual goals more attainable. As the world has grown older and more complex, the need for associations has grown more urgent and their purposes have become more clearly defined. This is true also of professional associations. If, in this society which we know today, and far beyond the foreseeable future, the professional person is indispensable to human welfare, then the contribution of professional people to human society will, in a large measure, depend on their ability to act together.

We represent professional nurses from all parts of the world. We work under every existing condition — political, economic, geographical and climatic. We are deeply integrated into the fabric of our countries and these countries vary in terms of national aspirations. Notwithstanding the possibilities of division inherent in the variety of backgrounds that make up our profession, we are all united in a common purpose and a common goal. In this unanimity of purpose we are indeed fortunate since, in a world full of conflict, it provides a broad international basis for mutual effort, interest and understanding.

Unity of purpose and common goals have little meaning without a constant and conscientious effort to achieve them. Nor do these goals themselves remain stationary. In all societies of the world they are constantly subject to movement and change. Just as constantly, the purpose, methods and means of nursing action within changing societies need to be re-appraised and re-directed. The members of the nursing profession cannot stand aside, with indifference, from the forces which are constantly bringing about change in the world. We are part of them. To fulfill our purpose in life it is necessary to know them and understand them.

I will not attempt to document here the various forces which are clearly at work in the world today. Mention of just a few of them will be enough for this discussion. Around us, in every country, we can observe:

> *A striving for education.* The rising level of education among the people of the world, together with the development of mass communication media which function in many instances with the speed of light, have resulted in new and changing concepts of human rights, human well-being and human behavior.
>
> Coinciding with rising levels of education has been a veritable *revolution in science and technology* which has profoundly affected medicine and nursing.
>
> The wider horizons opened by educational and scientific advances have been accompanied by *increasing anxieties* among the people of the world, anxieties which may be of mental or economic origin.

It is in a world constantly changed by such forces that the nurse must

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Miss Girard, who is Director of Nursing at Hôpital St.-Luc, Montreal, is the immediate past president of the Canadian Nurses' Association.

work. To be true to her profession she must work effectively. To be true to our trust, as responsible members of an association of nurses, we must help her to do so.

To understand the value of any association for the individual or the value of the individual to the association, let us make an analogy of the structure of organized nursing at its various levels with that of the human body, considering the nurse as the primary unit in this structure, that is, the cell.

Anatomy has taught us that human cells have different functions to perform and that, in order to play their roles in the structure of the human body, cells which are similarly specialized aggregate into units of various orders, constituting the tissues and the organs that are grouped together into systems. Each cell must contribute its essential part to the tissue to which it belongs, because the organization of the body is dependent on the need for each part, no matter how small, to contribute its share and to work for the good of the whole. Through the study of physiology we are further impressed with the remarkable correlation of the functions of various organs, and with the compensatory mechanisms set into operations by changes in the environment, all of which have but one object: to keep the body in a steady state regardless of the changes which take place internally and externally.

Is this not also the immediate end or goal of an association? To bring together each unit or individual to take its place in the structure and, to contribute to that structure the strength which will help it weather the winds and keep it steady even though this structure may be, and indeed will be, if it is at all progressive, in a constant state of change. Like the human organism which is adapted both physiologically and psychologically to change, the structure of a professional association must also have its stabilizers to enable it to keep an even keel while each unit is constantly being transformed by social forces which affect its role as well as its functions. Lewis Mumford, the American sociologist, has stated that:

> . . . The very extension of the range of community in our time, through national and world-wide organizations, only increases the need for building up as never before the intimate cells, the basic tissues of social life; the family and the home, the neighborhood, the working group and the city.

Nursing has been influenced more than any other profession by the extraordinarily rapid rate of social and cultural changes which have threatened its identity and relationships. Therefore it must find stability and strength in its associations based on unity of purpose and goals and in mutual responsibility. An association can give unity and direction to these strengths and aspirations; it cannot provide the strength itself, for only individuals can do that.

The purpose can be found in the civil law definition of an association as a convention by which two or more persons pool together in a permanent way their knowledge or their activity for a purpose other than sharing a pecuniary gain. This implies, as a characteristic feature, the communication of views and of ideals among members; it also implies an agreement of purposes and consequently it is in the nature of a contract. It means a willingness on the part of each member to be bound to the others as a means of reaching the objective for which the association exists.

Common activities tend to create among members a spirit of loyalty and solidarity, and a sense of unity which could be called vocational consciousness. As the association reaches a greater number of members it also implies power, scope and influence. Belonging to a professional association is a privilege. It means belonging to a selected group who are duty-bound to consider collective benefits rather than individual achievements; it means taking pride in serving a calling which is recognized as being bigger than oneself and more significant in the life of the community.

Professional nursing associations have a vital role to play in the community. With the rising levels of education in all countries, there has come a rising general belief in self-determination — a government by the consent of the governed. This means that, to be effective, an association must be effective through people, that is, by obtaining their understanding and consent. This principle, which leads to the most satisfactory human relations, is the one which should govern our public relations.

Understanding and acceptance from the community in which she works will be available to the individual nurse — and hence to her entire profession — if the community finds it has satisfactory answers to these questions:

> How are nurses dealing with the growing demands made upon the profession?
>
> Are they striving to meet these demands?
>
> Are they keeping pace with the advances made in other professions?
>
> Do they plan for constant re-evaluation of their methods and goals?

When the answer to any of these questions is negative or indistinct, the working conditions of the nurse and the profession are heavily handicapped. When the answer to each of these questions is "yes," the highest goals we set, as individuals or as a profession, are within reach. It is against this background that an association of nurses must work.

Therefore, if we believe in the axiom that "the deepest need of any organization is to be needed," we must be certain that the community appreciates the need for professional nursing. If it does — and *only* if it does — we may be confident that it will be ready to safeguard professional interests and standards.

One of the first responsibilities of any professional nursing association to the community it serves should be the desire to understand the needs of the people, to seek the counsel of leaders in different spheres, to encourage its own members to take part in varied community programs, and to participate with other groups in activities which help the community's welfare. Nurses, in general, have been much too silent about their professional endeavors and seem to have only recently learned to share their problems with and to take counsel of other lay or professional groups. By this aloofness the nursing profession can deprive itself of the vital interest and support of the people it is striving to serve. How conscious have we been of our role in the enlightenment of legislators and civic officials about the repercussions of social changes on the nursing profession? Have we been content to think this duty was being taken care of on the national level, when we all know the important role that members can play at the unit or cell level? The answers are amply evident to us every day, politically as well as economically.

If the final and deepest obligation of the nursing profession is to the patients entrusted to its care, it will fulfill this obligation in the measure in which it recognizes its responsibility to the community. Safeguarding and improving the vitality of our human resources should be our prime objective and the failure in some areas to keep up an adequate supply of professional nurses has already made the nursing profession deficient in the public's eye.

Important among current trends which will put a strain on nursing forces is the burden of an aging population plus the inadequacy of modern homes for the care of the sick, the highly scientific medical discoveries and the development of government or privately sponsored plans designed to give wider distribution of health and medical care, not only to the patient but to the family and the community.

If the nursing profession has responsibilities toward the community — and we have seen that it has — it is no less true that it also has responsibility to its own members. To be more specific we shall consider national nurses' associations and their responsibilities.

National associations can differ widely. Among the number that hold membership in the International Council of Nurses there is a great variety of patterns and structures. Whether they be called associations, federations, alliances or leagues, they usually coordinate the activities and functions of small groups. The latter serve as the link between the individual nurse and the national association and enable the profession to speak authoritatively with one strong voice when it interprets its aim and objectives or opposes measures contrary to its policies or purposes.

Dr. Allan Gregg, Vice-President of the Rockefeller Foundation, feels that the avowed purpose of a national association may be to serve its constituent members by reconciling internal differences, protecting collective interests and providing a forum to express the consensus of its members' views. The *raison d'être,* the common justification and the essential vitality of a national association should be derived from the fact that in a democratic society the citizens can exercise individually and by association the eternal vigilance that is the price of liberty. They do not have to leave what interests them to the experts or to a government bureaucracy. They do it themselves. In essence, Dr. Gregg says a national association disputes the finality of any control from above downward.

The Rev. Joseph Nunier speaks along the same lines when he states that

> because it is better fitted than any other group to achieve its goal and perform its proper functions, the professional association has the right to exist as a self-determined group with internal self-regulation. As an organic part of society, it cannot be super-imposed on that society but must grow from within. The germ of this growth cannot be a compulsory plan imposed by government nor forced structure from the higher echelons to the lower but rather the individual conscience, well-disposed and educated to the idea and to the need of professional service cooperation.

This is obviously a slow and tedious process, but it is the only really effective one, because vital action must be imminent action. The sound professional association is not dependent for its success solely on a chart, on bylaws, or boards and committees, not on well-defined policies and objectives, but to a large extent on healthy productive human relationships and on well-informed participation that is steady and imaginative.

Whatever its structure or mode of operation, a national nurses' association should be directly or indirectly concerned with:

> setting and maintaining high standards of professional education, practice and research; seeking economic security for its members; creating for them an image of what nursing should be and interpreting how it is trying to set conditions for this image to become a reality.

In many instances the ordinary member of our profession is in the same dilemma as the general public as to where she stands today in the midst of all the various levels of nursing practitioners, and especially, in the conflicting plans being evolved by the leaders of various beliefs, ideologies and philosophies of nursing education. I am sure you have all heard some people, and especially doctors and hospital administrators, sum up their ideas about the nursing profession by saying: "They simply don't know what they want."

Fundamentally, we are all sure that what we want is to give basically sound and intelligently administered nursing care and service to all people who need it, whether they are aware of this need or not. Yet, our ordinary member, who is willing and happy to be by the bedside giving this care, feels that she often finds herself either pushed aside from her satisfying task to leave it to some other non-professional worker or pushed upward to direct other people to do the tasks which she herself would prefer to do. She may then feel that for this latter role she needs more or better preparation which she proceeds to get by formal courses or study, from which she often returns, not better equipped for the specific tasks of helping these other persons, but with a broader education that has often taken her into many fields of knowledge outside of nursing. The assumption is that this will make her a better nurse.

To many of us this does not sound real, but I assure you that it does to a great many general practitioners in nursing as well as to the public at large. This procedure is one manifestation of the forces and influences mentioned earlier. It may be because of this that Dr. Leo Simmons of Columbia University made the following statement: "One of the dilemmas of nursing is that the further one progresses in the profession, the further one moves from the patient." This unfortunately is also the general impression of the medical profession and the public.

In creating an image of what nursing should be, could there not be emphasis on superior performance in just plain nursing? This, by the way, is the title given to booklets prepared periodically by Miss Ethel Johns, a Canadian nurse of international renown.

The professional association has a responsibility to look ahead, to recognize the changing scope of the profession, to search out new functions that it should assume. Should it not also preserve old standards and practices of proven worth while incorporating new standards and practices of emerging worth? Because of the general concern of nursing educators with professional education, attention has been focussed on such factors as the change in skills, techniques and practices to keep pace with the advances in medical, social, physical and natural sciences. First of all, let us remember that we are educating nurses for service. We no longer believe that this service depends solely on technical skills. Esther Lucille Brown in *Nursing for the Future* cautioned us in this way more than 10 years ago:

> Nursing is sometimes so broad in scope and profound in nature that technical competence is only one of its components. Technical competence alone would not supply that discriminative judgment, that alert self-direction, that skill in directing work and action on the basis of an understanding of human behavior and human relationships. It is these values that raise nursing from the level of a craft to that of a profession, that distinguish the professional nurse from the person whose almost exclusive preoccupation is with the prescribed physical care of a sick person.

The professional nurse is expected to have competence in making clinical judgments, sufficient understanding of underlying principles and behavioral sciences to assess the various factors in nursing situations, to assist in planning and directing nursing care given by others working with her, to gain insight into the patient's social and economic problems and to participate with other professions in the formulation of plans for positive health for individuals, families and communities.

Since it seems generally agreed that this is, in essence, the kind of professional nurse we wish to produce, it remains the responsibility of the profession not only to gear its educational institutions to the type of programs which will be likely to produce this person but also to create the atmosphere which makes this possible and stimulates her development. The professional nursing association should then proceed to define clearly what type of auxiliary personnel would better complement the role of the professional nurse; it should state what their preparation should be as well as their number in relation to professional nurses.

To this end, national associations are responsible for setting up the machinery which is necessary to assess nursing strengths and weaknesses in view of the major social and economic trends which are apt to effect it in the years ahead. This is what Robert Merton calls the committee of the Forward Look and the American Nurses' Association, the committee on Long Term Goals.

When this is done, the professional association has to interpret its programs to its general membership and to the public which is expected to support financially what it approves, and to recognize what it receives as being consistent with what it demands. This should be the basis of good public relations between the nursing profession and the community. The nursing profession should make use of all the tools of modern methods of communication. The nurse is fortunate in having a good audience at her disposal: the patient and the public which she serves. People are apt to view nursing in terms of what it means to them and their immediate range of interests, and nurses should not miss the opportunities of their daily contact to promote mutual understanding. Every nurse, whether she is conscious of it or not, is constantly influencing through her behavior, professional or otherwise, the attitude of the public toward the profession. If she learns through communication skills to be articulate in interpreting to the public the objectives of her profession she can and should be its powerful agent. National associations are more and more aware of the impact of good public relations programs not only in improving communications between their members and the public but also in influencing favorable relationships with members of other professions.

The role of the nurse in society, as well as her economic security, will depend largely on the image she creates for herself in the public's mind. She is a dedicated member of society and, at the same time, the society in which she works is one with local, regional and national aspirations. In most parts of the world, particularly those where democracy in its many phases is practised or sought, national aspirations will have two particular aspects: the desire and hope for a rising standard of living and the strong likelihood of trouble if this hope is denied. These two factors, again, spring from the social forces at work throughout the world.

As a member of society, the nurse has every reason and every right to be concerned with these hopes and possibilities, as they apply to her profession. There is, in the nurse, a high content of dedication to her calling — and this is as it should be. There is also, in the nurse, a high content of human nature which demands certain levels of human comforts. This is as it will be. It is neither reasonable nor realistic to assume that the aspirations of the nurse are separable from those of her society which expects a higher standard of living. Should this be denied, there can be only one result — fewer women will enter the profession. Under the immutable laws of work division this can lead only to diminishing nursing service, a denial of the goals of nursing.

The professional association can and should be concerned with the economic as well as the physical well-being of the nurse. In providing guidance in this area, it is necessary to understand clearly the division between what is desirable and what is possible. It is necessary also to understand that a service profession such as nursing can obtain economic security only with the approval and acceptance of the society in which it works.

There are, within the profession of nursing, two basic questions which will have to be asked by each generation of nurses; are there enough nurses? Are the services they provide good enough? Neither of these questions can be answered on the basis of economics alone. But, with equal emphasis, I suggest that the answers cannot be divorced entirely from economics.

The term "economics" here is used to mean the welfare of the nurse. This includes all those things to which every human being aspires — opportunity for higher standards of living; opportunity for advancement; recognition of the usefulness of the work done; good working conditions; reasonable hours of work; opportunities and machinery for redress of misunderstandings; security of employment; security of comforts of life after the years of employment have passed. If all these things are inherent, in some measure, in the aspirations of every society, their fulfilment depends on the ability — and not desire — of the society to meet them. Can we continue to attract and qualify new members of the profession without fulfilling these aspirations? Can they be fulfilled without the full understanding and acceptance of society? The answer is "no." It is equally apparent that the individual nurse cannot, alone, deal with these conditions. It becomes the function of the professional associations to do so — and this can be done only by creating and maintaining an atmosphere in which society permits this to be done. I would like to pause here to pay tribute to the International Council of Nurses' executive for their vigilance in this matter. They have been wise in realizing the value in working with the International Labor Organization in order to give leadership to national nursing associations in this important subject, and in creating, to this effect, a division of nursing economics.

There is another aspect in the responsibilities of the nursing profession which I have not yet mentioned and this is research. Not knowing whether Dr. Jahoda would agree that we have enough of the necessary qualifications, I have taken the liberty of casting away the doubts that were in my own mind, to assume that *nursing is a profession*. The immediate question that follows this statement is: do we have a professional approach in our methods of solving our problems and in planning for the future growth and development of the profession?

Being a professional person involves more than status. It involves responsibility. It commits the profession to the unending task of increasing the knowledge it applies to its professional activities. It commits the members of the profession to a willingness to be critical of their existing knowledge and practice. It suggests the capacity for self-criticism by which an informed group can re-direct its thinking, enlarge its knowledge, and compel the profession to a never-ending program of improving its performance.

Improved performance starts with education. That phase of education which is climaxed by a graduation ceremony is but a preliminary phase. Education is a life-long process and the interest and ability to use the educational opportunities available in day-to-day work is what distinguishes the professional.

Educational programs, like all forms of human activity, require organization and direction. It is necessary that the education received by undergraduates be integrated and complete, because this is the introduction to the profession and the base on which additional learning may be erected. As stated before, a nurse's education should be an education for service.

It is the changing nature of nursing service which is demanding more and more of nursing education. This change in nursing service includes many functions that were not expected of the nurse a decade ago. It requires the capacity to plan and to plan well. It requires the ability to deal with the mental as well as the physical aspects of the patient and his family.

These concepts of service and education cannot be separated from research. Indeed, membership in a profession of any kind implies a responsibility for research. How else could we keep pace with the revolution in science and technology going on around us if we could not, through research, roll back the frontiers of present knowledge?

Dr. Lester Evans, in an address given at Louisiana University Centennial, states:

> The skills, techniques and practices of your occupations will inevitably change with the advancement of knowledge but the fundamental nature and behavior of the people with whom you live and work will not. There is greater need now than ever before for men who understand men and the works of men. Progress is being made in the social and behaviorial sciences and the humanities and the arts, but the momentum and range of inquiry is not so great. Yet it is in this area that more must be known if man is to deal adequately with the circumstances of his life. The educated man must be master of his technology not subservient to it.

It is unfortunate, perhaps, that mention of research evokes images of lavishly equipped laboratories and highly specialized scientists. This, it is true, is one aspect of research that has led to vast advances in knowledge. But there is another aspect, one in which we all can and should participate, one which led in the past and will lead in the future to new developments. The equipment required in this phase of research is available to all of us. It is simply this — an enquiring mind. Without objective curiosity, without the enquiring mind, the most elaborately equipped and brilliantly staffed laboratory will accomplish little.

Mr. Krout, vice-president of Columbia University, when speaking to nurses used two illustrations to dramatize the research potential of the average nurse: First, the discovery of penicillin which came about because someone noticed that bacteria would not grow on a certain media where mould had inadvertently developed. That person did not say, "Well, let's not have it happen again." He asked "Why?" and proceeded to find out.

In somewhat the same manner, someone noticed that certain minerals clouded films when laid side by side. The laboratory assistant could have been told to "Please be more careful next time," but instead he was asked why this could happen, and the investigation that followed started a chain reaction which opened up the whole field of nuclear physics. In each case it was an enquiring mind that led to a discovery.

Nurses all over the world have the opportunity to train their minds to enquire — and when they do, new information and new insight into the field of nursing will be the results. In this, as in other areas of nursing, every nurse can contribute and help to enlighten and enrich her profession.

Summary

The functions of professional associations are to inform, guide and stimulate individual members as well as organizations in initiating sound thinking as well as critical judgment in the formulation of plans, policies and programs which will affect the future of nursing.

In this task the national nursing associations are fortunate in that they do not stand alone but are lined together as one strong chain which encircles the globe. This chain is the International Council of Nurses from which national associations expect guidance and wisdom. Through its constant contacts with member associations it is expected to gather information on new theories, new developments and new avenues of service, to evaluate and to disseminate information which can benefit all. It is expected to give special professional assistance to those member associations who are still struggling with the growing pains that accompany the development of all young organizations and particularly those working under adverse conditions.

It is expected, because of its choice position as the center in the world of nursing, to look beyond the horizon and visualize on a broad scale how the profession can improve its service to humanity.

This is a job which transcends all boundaries, all politics, all faiths, and language is no barrier because nurses all over the world speak one common language, which Miss Bridges has called "professional integrity," and profess one religion in common, which is to do good.

It is also expected of the International Council of Nurses that it will use its prestige as the first international association for professional women to see that nursing is represented in all world organizations where the rights and the interests of nurses are concerned, as well as where the profession can contribute to the welfare of mankind.

Let us remember, also, that information knows no boundaries and that information is the basis of wisdom. If the International Council of Nurses is helpless without the support of its members, it is also useless unless it, in turn, gives help and support. It is important that this interdependent need should create the kind of human relationships which foster peace and good will. Miss Nightingale no doubt had this in mind when she said: "Professions like nations can only flourish through an individual sense of corporate responsibility." Douglas Mallock conveys in a few words the essence of what our relationships should be in a poem entitled "Builders All."

> Someone has blended the plaster
> and someone has carried the stone
> Neither the man nor the master
> ever has builded alone.
> Only by working together
> things are accomplished by man;
> All have a share in the beauty,
> all have a part in the plan.

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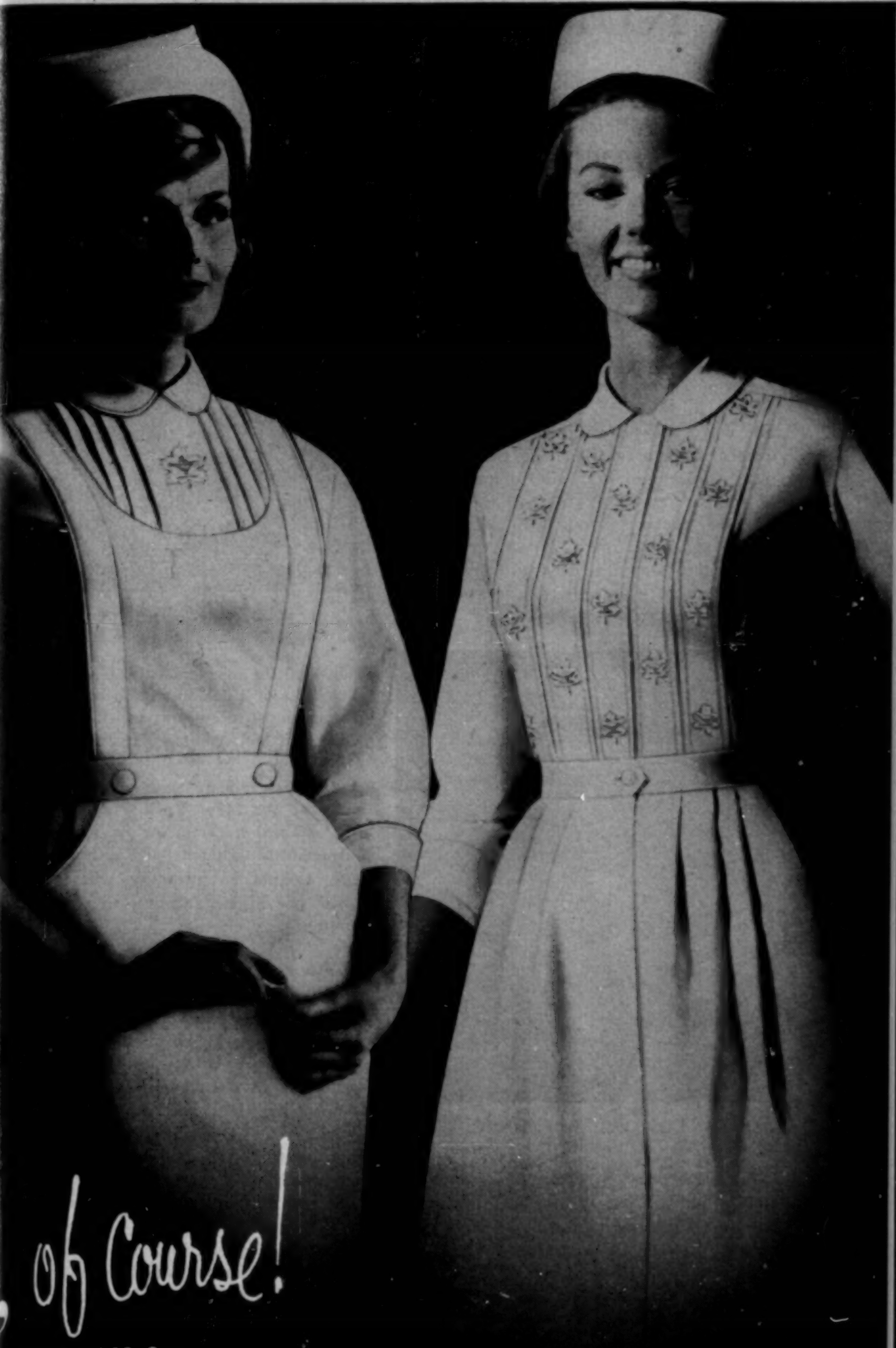

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NURSING PROFILES

The Canadian Red Cross Society has announced the recipient of its second fellowship for graduate study in nursing. Under its sponsorship, **Margaret Allemang,** a 1940 graduate of the University of Toronto School of Nursing, will return to the staff of the University to assist in the development of nursing research. Miss Allemang received her B.Sc. in 1947, her B.A. in 1949. In 1956 she obtained a Master's degree in nursing from the University of Washington, Seattle. She has just completed one year of predoctoral study at the same university.

Her professional career to date has been largely in the field of nursing education. She was a nursing instructor and later educational director at Belleville General Hospital, Ontario. In 1951, she joined the staff of the School of Nursing, University of Toronto where she taught in both clinical and public health areas. It was during this period that she developed her interest in research that eventually led to specialized study and her present undertaking.

Margaret Allemang

Joan Dorothy Morison has joined the staff of the University of British Columbia as public health nurse supervisor in the child health program. A graduate of the Vancouver General Hospital and of UBC, from which she holds her B.A.Sc. in nursing, Miss Morison has had extensive experience in the public health field, first with the provincial Department of Health in British Columbia, then with the World Health Organization as a member of a demonstration team in Ethiopia, and most recently as assistant supervisor with the Metropolitan Health Committee, Vancouver.

Joan Morison

Her postgraduate experience has included study at the New York Polyclinic, where she obtained a certificate in supervision of outpatient departments, and at Teachers College, Columbia University where she obtained her Master's degree in public health nursing.

Leta Sanders was appointed lecturer in nursing education at Assumption University, Windsor in September 1960. A graduate of Kingston General Hospital, Miss Sanders studied at the University of Pennsylvania and the Boston Lying-In Hospital prior to joining the RCAMC during the second World War. Her military experience included duty in Canada, England and Holland.

After several years on the staff of the Isolation Hospital, Toronto, Miss Sanders enrolled at the University of Western Ontario from which she obtained a diploma in teaching and supervision. She subsequently taught tuberculosis nursing at the Mountain Sanatorium, Hamilton. In the intervening years, Miss Sanders completed requirements for her bachelor's degree in

LETA SANDERS

nursing and a master's degree in teaching and curriculum at Teachers College, Columbia University.

Claribel McCorquodale Richards has been named executive director of the United Nations Association in Canada, National UNICEF Committee. This marks another milestone in an interesting and varied professional career that began with Mrs. Richards' graduation from Memorial Hospital, St. Thomas, Ont.

Following a short time as night supervisor in Memorial Hospital, Mrs. Richards worked as an operating room supervisor, Cottage Hospital, Toronto; as surgical supervisor, in the Medical Arts Building, Toronto and for a number of years as supervisor of nursing service in the Department of Radiology, Toronto General Hospital and the Cancer Institute of Ontario. When the International Council of Nurses began planning for its first postwar congress, Mrs. Richards was placed on loan to its staff in the capacity of associate executive secretary to assist with preparations for the Atlantic City meeting. She remained with the ICN until 1951. The years 1952-58 were occupied with duties as coordinator of the Treatment Services for Crippled Children for Ontario. At the end of this time, Mrs. Richards was asked to carry out a special study for the Canadian Mothercraft Society, Toronto, in the position of executive director.

Her previous experience in relation to the care of mothers, babies and older children was particularly helpful to her now. As a Nightingale scholar at Bedford College for Women, London, England in the hospital administration course, she had had an opportunity to see Mothercraft at its peak in that country before the National Health Service had come into effect. Special study in education of the handicapped at Syracuse University, New York had increased her appreciation of the particular needs of children. A travelling grant from the Rockefeller Foundation made it possible for Mrs. Richards to visit various centres for mother and child care in Canada and the United States as part of her study for the Canadian Mothercraft Society. As a result of her recommendations to the Society, steps will be taken to correlate its activities with those of other agencies concerned in the care of children. An improved public relations program will make the work of the Society better known to the community as a whole.

(Joseph Schmid, Toronto)

CLARIBEL RICHARDS

Mrs. Richards' administrative abilities have earned for her many interesting assignments. The present one holds great promise as another field in which to exercise her professional talents.

To clean the oven, try leaving a saucer of ammonia in it — with the door closed overnight. Next day, wash it out with warm, soapy water.

THE WORLD OF NURSING

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Health Care

The Royal Commission on Health Care held its first meeting in Ottawa on June 28. The Commission chairman, Chief Justice Emmett M. Hall, said that terms of reference are very broad and affect the lives of all Canadians. The Commission provides opportunities for people in all walks of life, for the professions, for organizations, institutions and associations and for governments at all levels to submit briefs and to be heard in public hearings in various cities from coast to coast over a two-year period. The Commission will take a close look at health plans in other countries in the search for the most effective and beneficial ways of meeting the health needs of Canadians.

The Commission also plans to undertake a program of research studies and investigations, supplementing the work already done in this field by governments, institutions, universities and other organizations.

CNA School Improvement Program

This program, which is focused on self-evaluation by the schools of nursing in Canada, is going into its second phase. One hundred and fifty schools have indicated that they wished to participate. They were sent questionnaires as the first step in self-evaluation.

Regional conferences for interpretation of the program have been planned for this fall with at least one conference in each province. The purposes will be.

To interpret the objectives of this program to hospital administrators, boards of control and other administrative groups of the participating schools, and to key people in the health field;

to assist instructors of schools of nursing in evaluating their educational programs through use of the Self-Evaluation Guide.

It is anticipated that the Self-Evaluation Guide will be completed by the staff of the schools of nursing by May 1962. These Guides will then be reviewed to ascertain the factors in the educational programs which require study and improvement. The staff of the schools will also be asked to identify areas of the educational programs in which they would like assistance. On the basis of this information, regional workshops will be held commencing in the fall of 1962, to provide assistance in the areas indicated.

CNA National Office Auxiliary

September marks the beginning of activities in all areas of nursing as plans unfold for improved care to the public we serve. Equally eager to help in this service, though not in the close person-to-person contact of the nurse with patient relationship, are the members of the CNA National Office Auxiliary. These members, all nurses, maintain a close liaison with CNA headquarters.

Established in 1955, with approval of the CNA Executive Committee, the group began by cataloguing and maintaining the archives and by entertaining international nurse visitors who come to Ottawa during the course of their study programs in this country.

Each member played an active part in committee work for the CNA 50th Anniversary Convention in 1958. For the past two years, on invitation of the

Ottawa Area Chapter of District #8, RNAO, the Auxiliary has served refreshments at Chapter meetings. Proceeds from silver collections are allocated to the CNA House Fund. In this way the Auxiliary hopes to share and assist in the building of our own national headquarters.

In addition to these continuing activities, the group assists with some clerical duties such as typing and with proofreading of printed materials, as the need arises.

The newest project is the cataloguing and indexing of the numerous periodicals received in National Office. In order to maintain this activity a full-time worker would be required. Working with assigned CNA staff, the Auxiliary is helping maintain this project, which results in more readily obtainable reference material for enquiring nurses.

With ten active members and four inactive members who are on call to assist with the above projects when required — the Auxiliary follows a busy schedule. The interest and enthusiasm of the group is evident. Provincial associations considering the formation of similar groups will find that these ladies are excellent links between their associations, hospital alumnae and other women's organizations where support for nursing projects may be secured.

Emergency Health Services Advisory Committee

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THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

Health Care

The Royal Commission on Health Care held its first meeting in Ottawa on June 28. The Commission chairman, Chief Justice Emmett M. Hall, said that terms of reference are very broad and affect the lives of all Canadians. The Commission provides opportunities for people in all walks of life, for the professions, for organizations, institutions and associations and for governments at all levels to submit briefs and to be heard in public hearings in various cities from coast to coast over a two-year period. The Commission will take a close look at health plans in other countries in the search for the most effective and beneficial ways of meeting the health needs of Canadians.

The Commission also plans to undertake a program of research studies and investigations, supplementing the work already done in this field by governments, institutions, universities and other organizations.

CNA School Improvement Program

This program, which is focused on self-evaluation by the schools of nursing in Canada, is going into its second phase. One hundred and fifty schools have indicated that they wished to participate. They were sent questionnaires as the first step in self-evaluation.

Regional conferences for interpretation of the program have been planned for this fall with at least one conference in each province. The purposes will be.

To interpret the objectives of this program to hospital administrators, boards of control and other administrative groups of the participating schools, and to key people in the health field;

to assist instructors of schools of nursing in evaluating their educational programs through use of the Self-Evaluation Guide.

It is anticipated that the Self-Evaluation Guide will be completed by the staff of the schools of nursing by May 1962. These Guides will then be reviewed to ascertain the factors in the educational programs which require study and improvement. The staff of the schools will also be asked to identify areas of the educational programs in which they would like assistance. On the basis of this information, regional workshops will be held commencing in the fall of 1962, to provide assistance in the areas indicated.

CNA National Office Auxiliary

September marks the beginning of activities in all areas of nursing as plans unfold for improved care to the public we serve. Equally eager to help in this service, though not in the close person-to-person contact of the nurse with patient relationship, are the members of the CNA National Office Auxiliary. These members, all nurses, maintain a close liaison with CNA headquarters.

Established in 1955, with approval of the CNA Executive Committee, the group began by cataloguing and maintaining the archives and by entertaining international nurse visitors who come to Ottawa during the course of their study programs in this country.

Each member played an active part in committee work for the CNA 50th Anniversary Convention in 1958. For the past two years, on invitation of the

Ottawa Area Chapter of District #8, RNAO, the Auxiliary has served refreshments at Chapter meetings. Proceeds from silver collections are allocated to the CNA House Fund. In this way the Auxiliary hopes to share and assist in the building of our own national headquarters.

In addition to these continuing activities, the group assists with some clerical duties such as typing and with proofreading of printed materials, as the need arises.

The newest project is the cataloguing and indexing of the numerous periodicals received in National Office. In order to maintain this activity a full-time worker would be required. Working with assigned CNA staff, the Auxiliary is helping maintain this project, which results in more readily obtainable reference material for enquiring nurses.

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Second degree burns of the face, neck and genital regions are more satisfactorily treated by the "open" method (without a dressing), after debridement. This avoids irritation from friction and possible infection. Burns on the anterior part of the neck are best treated by posturing the patient on his back with the neck in hyperextension. The latter may be secured by placing a pillow beneath the patient's shoulders or placing him on a Bradford frame. The nursing care of patients with genital burns is made easier if the hips are elevated from the mattress using traction on the legs similar to that used in fracture of the femur.

Third Degree Burns: They are a severe trial for the patient as a result of pain, morbidity and often death. Such burns are accompanied by permanent scarring. They tax medical services to the limit in the demands made upon nurses, doctors, nursing auxiliaries and orderlies to meet the patient's requirements for care. Few other conditions make such demands over such long periods of time.

A Burn Treatment Centre

In order to provide the optimum in care for the severely burned and also not deprive other patients of the care that they need, it is a very useful arrangement to concentrate patients with burns in a specific area of the hospital — an intensive care unit.

Ideally, the burn centre should have two to three rooms in which burned patients can be individually isolated during the acute phase or if an infection develops. In addition there should be a small ward for patients in the convalescent stage to provide more diversion. An adjacent dressing room is a necessity. Proximity to the physiotherapy department and its facilities for hydrotherapy and occupational therapy is highly desirable.

Nurses and internes assigned to duty in a burn centre quickly become expert in the type of care required. Since the care of the burned is their particular responsibility and not something extra added to the regular routine of medical care the personnel can give all the attention necessary. The patients do not have any feeling of being a burden and the confidence that they develop in those who care for them speeds up the healing process noticeably. Isolation of burned patients, who almost invariably develop an infection at some point in the treatment, decreases the risk of contamination in the rest of the hospital.

A burn centre can provide 90 per cent of the care required by the patient. Only debridement and skin grafting need the services of the operating room. This frees the operating theatres for other purposes.

Treatment of Third Degree Burns

Acute Phase: This stage lasts around 48 hours. The details of treatment concern the doctor in particular. They include replacement of blood, plasma and electrolytes, sometimes in massive quantities.

Each patient must be individually evaluated and treated. Careful observation (at least once every hour) of pulse, blood pressure, respiration, urinary output and density is necessary in gauging the type and quantity of intravenous fluid to be used. This implies a duty for the nurse in checking vital signs and maintaining accurate records.

Chronic Phase: There are two main features of this stage — debridement and skin grafting. As nearly as the third or fourth day, the burned areas should be freed of necrotic tissue so that grafting may be started approximately 15 days following the burn.

Between periods of debridement, the burned areas are kept clean by changing the dressings every 2-3 days. This is carried out in the dressing room. The patient receives a narcotic sedative and is put in a warm bath containing detergent. The dressings soak up the moisture quickly, loosen and can be removed without too much discomfort and without bleeding. While the patient is in the bath, the physiotherapist can take advantage of the opportunity to put the patient's limbs through a range of motion designed to maintain muscles and joints in good condition.

The patient is placed on a stretcher that has been draped in sterile sheets covered with a layer of sterile aluminum foil. The latter is easily sterilized, inexpensive and does not cling to the burned tissue. The dressing is done with aseptic precautions including the use of sterile gowns, gloves and masks.

A frequent change of dressing has greater value than antibiotics in lowering temperature and decreasing toxicity.

Skin grafting is done at as short intervals as possible (every week to 10 days) until the entire burned surface has been covered.

Maintenance of the General Condition

This is where the knowledge and ability of the nurse will make the greatest contribution. In actual fact, burned patients who are maintained in good general condition heal much more rapidly and recover more completely than those who become thin, stiff and debilitated.

Nutrition: It is a well-known fact that burned patients have little appetite. General discomfort, the effects of infection, the toxicity of open wounds, all combine to produce anorexia. The decreased ingestion of food associated with loss of protein from the denuded areas produces a lowered plasma protein level. An adequate protein level is indispensable in assuring that a graft "takes." The best surgical techniques will avail little in the presence of hypoproteinemia.

The nurse, by encouragement, suggestions and coaxing, must persuade the burned child to eat an adequate quantity of nourishing food. Experience has shown that most of the time even the burned adult will not eat enough to maintain plasma protein at an optimum level. Oral intake must be supplemented by gavages. An indwelling plastic stomach tube can be used and concentrated high caloric feedings given at regular intervals, usually three hours before the next normal meal to avoid destroying the patient's appetite. In this way, it is fairly easy to have a small patient take 3,000-6,000 calories a day. The gavage tube facilitates the administration of medications. Using such a routine tends to help the patient not only to keep his weight but to gain as well.

Physiotherapy: Burns tend to have a crippling effect in that they predispose to such things as flexion of the knee or a dropped foot. Such tendencies must be detected and corrected from the very beginning.

Knees should be gently but firmly extended. A footboard helps to prevent footdrop.

Occupational Therapy: The average duration of hospitalization as the result of a severe burn is several months. Patients quickly become bored, discouraged and may even despair of recovery. The nurse must help to forestall such tendencies by keeping the child occupied with games, stories, unexpected treats and so on. It is important to keep reminding him that he will be leaving the hospital some day. Often the child begins to believe that he will never recover or leave the hospital. The time seems so long and progress in his condition so slow.

Conclusion

These are the main aspects of the treatment of burns. It can be seen that third degree burns create problems. Burn centres, as set up in several North American hospitals, contribute much towards improving the quality of care. Morbidity and death are diminished in rates while nursing care is facilitated to a marked extent.

The International Labor Organization includes the following statements in the text of one of its new recommendations: "training is not an end in itself, but a means of developing a person's occupational capacities, due account being taken of the employment opportunities, and enabling him to use his abilities to the greatest advantage of himself and the community."

The text also describes training as a "process continuing throughout the working life of the individual," and that "training should be free from any form of discrimination on the basis of race, color, sex, religion, political opinion, national extraction or social origin."

—*I.L.O. News,* July, *1961*

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WHO Public Health Papers No. 7 "Basic Nursing Education Programmes, A Guide to their Planning" by Katherine Lyman, is now being distributed. Single copies are $1.00; 10 or more copies are available at a discount of 50 per cent. Orders should be sent to: Distribution and Sales Unit, WHO, Palais des Nations, Geneva.

A RETURN TO NURSING

MARGARET J. B. THOMPSON, B.A.

From the viewpoint of a casual observer it would be difficult to improve on the many technical and practical advances that are in use in modern hospitals. Progressive patient care, however, may be another major step forward in our search for perfection in the nursing care of the sick.

Progressive Patient Care

PROGRESSIVE PATIENT CARE involves five phases in its entirety. Patients are classified according to their medical needs and nursing personnel according to their special abilities. Each physical area is designed and built to serve its particular function and the personnel trained, to their highest potential, to care for the patients in the particular section to which they are assigned.

Intensive Care

Because of the layout of each of the units in this area, six patients can be cared for on each shift by one professional nurse and one nursing assistant (either "certified" or trained through an in-service educational program), with the help of a second nursing assistant during the morning care period. All personnel who work in this area do so by choice, and receive special instruction in all aspects of the nursing care of the critically ill patient. Relief nurses are also given the advantage of this special teaching, so that it should never be necessary to assign to this area, a nurse who is not familiar with all the procedures used.

The professional nurse is responsible for the six patients under her care and reports to the head nurse of the intensive care area. As the units must, of necessity, be properly designed and appointed, the professional nurse does not have to leave her unit for any reason other than meals. She is visible to each patient, at any time of the day or night, by virtue of the location of her desk. Both the nurse and the unit are equipped to handle any emergency which might arise. The need for private nurses is eliminated.

Intermediate Care

The nurse who does not care to work in the constant "life-and-death" tension of the intensive care area, may choose to nurse moderately ill patients in the *Intermediate Care* zone. Here, she can help her patients plan their own care and has enough time to supervise their activities. Treatments and medications are usually routine. Because the nurse knows that she will never be called away from a patient to administer to the needs of another who is critically ill, she carries out her duties in a relaxed frame of mind, free from the disturbing, continuous motion that has become the symbol of today's hospital nurse. She transmits this tranquillity to her patients.

Continuation Care

The patient assigned to the area of *Continuation Care* has particular problems that need the understanding and compassion of the nurse who has special abilities in this field. These patients require long-term care. Many have multiple fractures or burns and require complete physical care; some are recovering from cerebral accidents; for some their illness is terminal.

In this section of the progressive patient care program the emphasis is on rehabilitation, the extent of which varies according to the condition and needs of the patients. The nursing personnel has a special responsibility for elevating and maintaining the morale of the long-term patients who are prone to despondency and discouragement.

Self-care

Many patients when they are discharged from our hospitals today, are

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Miss Thompson is Director of Nursing, Queensway General Hospital, Toronto, where a complete progressive patient care program will be instituted in the near future.

not ready to resume normal family life. For them, as for those who are admitted for diagnostic purposes, progressive patient care has set aside a special area — the *Self-care* zone. These patients must be sufficiently ambulatory to be able to walk to and from the cafeteria and other hospital services. Only one professional nurse is required, and as head nurse, she is responsible for the teaching and supervision of both patients and auxiliary staff. Patients are instructed regarding the limitations of activity and diet that their illness has imposed. Those admitted for diagnostic purpose are made familiar with the treatments they will undergo. As a result a feeling of confidence is created instead of the fears and misgivings experienced by so many patients under the present hospital system.

Home Care

The last phase of progressive patient care, *Home Care,* must be organized in cooperation with whatever public health services are available in the community. Hospital-based, it is an extension of hospital services into the home. When this phase is feasible, some patients may be treated successfully throughout their entire illness in their own homes.

Personnel

In the progressive patient care program, both professional nurses and nursing assistants are assigned only to the area of their choice. In addition to the special instruction in the procedures and skills required to nurse the patients in each section, a well organized in-service education program must be carried out so that the staff is kept abreast of the latest advances in nursing. The professional nurse is *nursing* at last, combining her ability, skill and knowledge to create an environment that is conducive to the recovery of her patient and the maintenance of health for his family and community.

Summary

It has been a challenge and a great privilege to plan the nursing service for a progressive patient care program. Service to mankind and the preservation of human life have always been the reasons for the existence of the nursing profession. If these objectives have been obscured in recent years, it is not the fault of nursing education, but rather, of the highly technical atmosphere that surrounds the patient which in turn, has taken the nurse from the bedside and transformed her into a technical expert.

This type of progressive care program is the most radical plan for patient care that has come before the nursing profession for many years. Its introduction will have the immediate effect of better patient care, rendered by a competent and dedicated nursing staff. Perhaps it is not too fantastic to hope that our experience may eventually affect the construction of future Canadian hospitals.

A new film, "The Prevention of Disability in Rheumatoid Arthritis," designed primarily for showing to the medical profession and produced under the direction of the National Medical Advisory Board of The Canadian Arthritis and Rheumatism Society, covers latest developments in the treatment of this crippling disease.

The 16 mm. color film, made possible by a contribution from the Bayer Company, Aurora, Ontario, presents a balanced program of effective treatment for the prevention of disability and illustrates special techniques useful in dealing with the complications which sometimes occur.

The role of the family physician in the prevention of disability is emphasized and valuable information for nurses, physiotherapists, and occupational therapists is given.

The film runs 27 minutes and is available from the National Office of The Canadian Arthritis and Rheumatism Society, 900 Yonge Street, Toronto 5, or from any of its eight provincial divisions across Canada.

* * *

Happiness should not be looked upon as a reward for a good life, but as the natural effect of it. You will be happy if you are exercising your vital powers along the lines of excellence in a life which affords full scope for their development.

— *The Royal Bank of Canada Monthly Letter.*

Pediatric Intensive Care Units

ROSELYN SMITH, B.N. *and* ELAINE BURT

At the Montreal Children's Hospital, an extension of recovery room services to incorporate a surgical intensive care unit has proved so successful that a medical intensive care unit has also been established.

What It Is

THE PURPOSE of an intensive care unit is to concentrate in one service area, all of those patients who are critically ill and who will benefit from highly skilled nursing care and close, if not constant, observation. It is becoming increasingly obvious that lives can be saved and morbidity reduced with the use of such a unit. The staff is trained to detect any changes immediately, to institute corrective measures, to decide when the situation requires more than nursing skills and to summon suitable assistance. The staff must be trained in the handling of special equipment — resuscitative machines, oxygen apparatus, cardiac regulating machines, hypothermia devices. Above all, they must possess the ability to work effectively under pressure in emergency situations and to carry out the necessary procedures with the least possible loss of time.

Its Ancestry

The idea of intensive care is not new. In the days of the large open wards of 25 to 30 beds, the most seriously ill were usually placed close to the nurses' desk. During the wars, casualties and postoperative patients were concentrated in areas close to the scenes of action only until their condition was such that they could be moved to larger, quieter areas farther away. These patients were kept under close observation and received more concentrated nursing care, even though specially trained staff, better facilities and separate areas were not available to them.

Special Features

In setting up such a unit, many special features must be considered, the most important being the location of the nurses' desk. It must afford a clear view of all patients and be adjacent to a call system to summon assistance when trouble arises. If the unit is included in the recovery room area, adequate allowance must be made to accommodate the patients on the average, daily operative schedule, as well as a given number of intensive care patients. We have found that a small group of nurses — four to six for day duty, two for evening and night duty — appears to work best. Each is interested in her co-workers' patients and problems, is ready and willing to give a helping hand when necessary. It is felt that six I.C. patients are as many as can be carefully handled by a nursing team of this size.

Equipment

Included in the special equipment kept in this unit are: thoracotomy and tracheotomy trays, and the necessary suturing materials; cut-down is a common procedure, and recovery room hemorrhage, though infrequent, must be anticipated; trays for tonsil and nasal packs, chest aspiration, catheterization and pressure dressings are kept at hand. Apart from the sterile trays, a surgical light is a must! A respirator, defibrillator and anesthetic machine should be close by. The unit should be provided with emergency lighting in case of power failure; if this is not possible, this special equipment should be of a type than can be battery controlled.

Some drugs — stimulants, depressants, vasoconstrictors and vasodilators, coagulants and anticoagulants, sedatives, analgesics, etc., should be stocked on the unit. Because some of these drugs are expensive and have a short expiry period, it might be considered a valuable economy measure to use this collection as an emergency

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Miss Smith is director of nursing, Miss Burt head nurse in the recovery room, at the Montreal Children's Hospital.

drug cupboard for the use of the entire hospital after regular pharmacy hours.

Each patient unit must be equipped with oxygen and suction and, although not absolutely necessary, it is very convenient to have a sphymomanometer on the wall behind each bed.

Surgical Unit

Our surgical unit is included in the recovery room area and the patients are cared for by the recovery room staff. This, we feel, is an extremely satisfactory arrangement on several counts. The recovery room staff nurse is used to better advantage. As a 24-hour unit, the doctors are assured of the availability of nurses whom they know and upon whom they can rely; the nurses are assured of having patients who need their attention.

The most difficult adjustment for recovery room nurses is the lack of continued patient contact — the patient is no sooner awake than he is taken to his ward and another unconscious patient takes his place. When the intensive care unit and recovery room are combined a patient sometimes remains for several weeks. The nurses' interest is aroused and maintained by watching and helping a critically ill patient gradually improve.

New drugs are introduced, new treatments instituted, stimulating new ideas are constantly being introduced, occasionally with dramatic results, and the discussions which arise are not soon forgotten. Such an atmosphere tends to draw the type of nurse who is suited to this kind of work and the challenges offered to her give the kind of satisfaction which results in a secure and stable staff.

The hospital acknowledges the economy of time, effort and money that is made possible with such an area. Here, a relatively small number of nurses may care for numerous patients who, if scattered throughout the hospital, could require three nurses each, every 24 hours. The doctors, when making rounds, remain in one area for perhaps half an hour; without the unit they might spend two or three times that long seeing the patients. The special equipment, trays and drugs kept in this area need not be issued to all wards.

Our unit is staffed entirely by graduate nurses as the only students at this hospital are affiliates who receive training in the care of both the post-operative and the seriously ill patient in their home hospitals. However, such a unit would be an excellent place for student experience.

For a 15-bed combined unit, with from three to six I.C. patients, we use a staff of 10, two of whom are on evening duty, two on night duty. This number is usually adequate but, at an extremely busy time, help may be obtained from elsewhere in the hospital. Likewise, at a less busy time, the staff may help on the other wards, with the understanding that they return when needed. Care must be taken that these nurses relieve only in the "clean" areas of the hospital, so that they can return to the recovery room at a moment's notice.

Because the unit is situated on the same floor as the operating rooms, surgeons and anesthetists are always available during operating hours. At night, the staff anesthetist, who is on call, sleeps in a room on this floor and is available should the need arise.

The type of patient assigned to I.C. will depend upon the type of hospital and whether the unit is strictly medical or surgical or both. Patients who have undergone surgery for tracheo-esophageal fistulas and atresias or who have had cardiovascular or thoracic surgery remain in our unit until after chest tubes have been removed and the overall condition has been stabilized. Post-tracheotomy patients remain for a minimum of 48 hours or until the secretions are no longer troublesome. Abdominal surgery of the newborn often results in difficulties when feedings are started, or resumed. These patients, therefore, remain in the unit until they are taking feedings well. Accident victims, especially those with head injuries, whether they have had surgical treatment or not, are kept in the unit until their condition is no longer critical. The surgeon, in agreement with the anesthetist, is responsible for the care given to these patients and has the final word regarding the time of discharge from I.C., whether it be a matter of hours, or of weeks.

Medical Unit

As has been stated previously, the main purpose of an intensive care unit is to provide the acutely ill patient with as much concentrated, skilled nursing care as is necessary, for as long as he requires it. This may be one day or several weeks, but once the patient is past the acute stage he no longer requires this type of care and he may be transferred to another area for convalescence.

In 1959, the decision was made to experiment with a medical intensive care unit. On many previous occasions, it had been necessary to provide private duty nurses to give the special care necessary; there were several disadvantages:

1. Many of these nurses had not worked with children for years and found it extremely difficult to cope with them. Frequently, a nurse would stay for one day only and consequently, the patient had a series of nurses. Since the nursing was very specialized and most of these nurses were not familiar with the equipment, the permanent nursing staff and the doctors spent a great deal of valuable time familiarizing each new person with her duties.
2. Because of these frequent changes, there was often a lack of continuity in care.
3. When private duty nurses were not available, it was necessary to draw nurses from the hospital staff, thus depleting the already busy wards of trained personnel.
4. Finally, but most important of all, the children in this area could not possibly adjust satisfactorily to such a variety of people attending them. They had no confidence in those caring for them and gradually became more and more disturbed, to the point where their progress was actually hampered.

The medical intensive care unit is very small, containing only three beds. Five graduate nurses are employed for the unit, so that there is always one for each of the three tours of duty. They are oriented to the unit by the doctor in charge, by the head nurse and teaching clinical supervisor. When the unit is empty, the nurses continue through their rotation and are placed where needed in the hospital, but are always available if and when a patient is sent to the area.

Special equipment and drugs and a direct line of communication for summoning medical help are provided.

Although the unit was originally set up for patients with respiratory insufficiency, it has been used for children who require intensive care and close observation for any medical condition. We do not feel, however, that facilities are adequate to give this type of care to the patients who are on isolation technique.

The medical wards have noted a considerable difference since they have been relieved of the worry of assigning ward staff to give this type of care to the seriously ill patient thus having to cut down on the amount of care given to the other patients. Pediatricians have said they are most favorably surprised at the many advantages of such a form of nursing.

For the industrial nurse — If you have the problem of workers who have body odor, perhaps this suggestion will be helpful.

Ask a handful of workers, including the offending individual, to help you with a "field test" of certain hygienic products. People are usually pleased to do this "as a favor," and it introduces them painlessly to the benefits of deodorants.

— *Squibb Nurses' Notes,* Vol. 10, No. 3

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The twelfth annual convention of the American Nursing Home Association will be held in Cleveland, Ohio, October 2 to 6. The principal theme will be planning, construction and financing of new nursing homes, the subject to be discussed at a series of small group round-tables.

Registration up to Sept. 15 is $38 for one person and includes all meals at the convention but not room charges. A second registrant from the same home will be charged a fee of $25. All sessions will be held at the Pick-Carter Hotel, Prospect and E. 9th Streets, Cleveland.

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Athletics are widely touted as representing the struggle of life in miniature. The difference is that, in life, there are no half-time periods, no trainees with oxygen when you weaken, and very few cheers when you are carried, recumbent, off the field.

A RESPIRATORY UNIT

Mary Ellen Flett, Mary McInroy *and* Elizabeth Nimmo

The art of artificial respiration has been known to mankind since biblical times, but until recent years, its use has been confined to accidents causing asphyxiation. As medical knowledge has progressed, it has been found that certain diseases cause respiratory distress that may be relieved by artificial respiration. This knowledge has produced the innovation of improved mechanical devices to meet this need.

How It Came About

Until 1958, patients with respiratory insufficiency were treated in tank respirators. These patients presented many nursing problems — pressure areas were common, the management of pharyngeal and pulmonary secretions was difficult, physiotherapy was almost impossible to carry out, and if patients could not swallow, secretions were aspirated and often caused pneumonia.

Until that time, patients on artificial ventilating machines were cared for individually on the various wards scattered throughout the hospital. Because many staff members were not familiar with the machines, this proved unsatisfactory to all concerned.

Out of these difficulties emerged the plan for an intensive care unit where a group of specially trained doctors and nurses could care for patients with respiratory distress. In October 1958, such a unit was set up and equipped with intermittent positive pressure artificial respirators. This has made possible the successful treatment of conditions that otherwise might have proved fatal or required more prolonged and difficult treatment.

Organization of the Unit

The unit is controlled clinically by four physicians — a neurologist, a chest physician, an anesthetist and an otolaryngologist. A Fellow in anesthesia acts as medical interne.

Each patient's unit requires a large amount of space to accommodate the bed, respirator and other necessary equipment. The special narrow, stretcher-type beds move easily, have built-in sideboards and removable heads and feet. They are slightly higher than the regulation hospital bed to facilitate nursing care.

On the head of each bed is an emergency apparatus that consists of a small oxygen cylinder with reducing valve and flow meter and a rebreathing bag for ventilating the patient during transportation or in the event of machine failure.

The nursing staff consists of a charge nurse, 13 graduates, two nursing assistants and three senior student nurses. This staff is not adequate for a six-bed unit. We recommend one graduate nurse to every two patients, with students augmenting the staff to care for the second patient.

The graduate nurses must be trained to develop technical skills and keen powers of observation. They are taught to take blood, give intravenous drugs, change tracheostomy tubes and pass gastric tubes. The ability to accept added responsibility in cases of emergency, when a doctor is not immediately available, is essential. The graduate nurse must also accept responsibility for the student nurse with whom she is working. They must be especially alert to changes in the machines or in the condition of the patients and anticipate these changes so that a quick and accurate decision may be made.

Volume and Types of Patients

In the first two years, we cared for 119 patients, with 29 deaths. The medical staff has estimated that over 50 per cent of the surviving patients would have died had it not been for

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This article was prepared by three members of the nursing staff of the Toronto General Hospital: Mrs. M. E. Flett, head nurse, Respiratory Unit, Miss M. McInroy, nursing service supervisor and Mrs. E. Nimmo assistant nursing service supervisor.

this unit, and the other 50 per cent would have taken at least twice as long to recover. The average length of time spent in the unit is four to six weeks.

Patients with the following conditions have been admitted to the unit:

1. Chest diseases, e.g. pneumonia and emphysema;
2. neurological diseases, e.g. poliomyelitis, polyneuritis, myasthenia gravis, tetanus, multiple sclerosis and status epilepticus;
3. postoperative depression of respiration;
4. intoxication, e.g. drug overdosage and gas poisoning;
5. injury, e.g. chest injuries and head injuries;

Methods of Management

1. *Clear the air passages* — In order to accomplish this, the patient's chin is held up to insert an oropharyngeal airway, to suction secretions, or to remove foreign bodies. The doctor may have to insert an endotracheal tube, a bronchoscope or perform a tracheotomy.

2. *Ensure adequate exchange of gases* — if a patient is not breathing well, he will need assistance in one of the following ways:

a. Mouth to mouth breathing,
b. face mask and bag,
c. endotracheal tube and bag,
d. tracheostomy tube and bag,
e. artificial ventilation machine.

Artificial Ventilation Machines

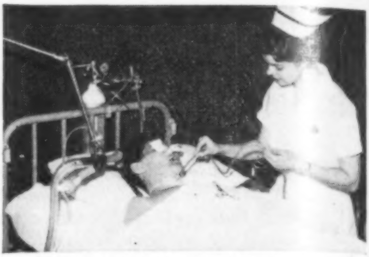
Tank respirators could be used, but because of the nursing difficulties involved they are not.

It has been found that giving oxygen alone is inadequate. The patient may become pink, but may die because he is not getting rid of carbon dioxide. Intermittent positive pressure machines help blow off carbon dioxide. There are two main types:

1. Those that work automatically when the patient is not breathing,
2. those that work when the patient starts a respiration, and augment it.

Some machines will do both; these come under two categories:

1. Pressure constant-volume variable: Bennett Respirator, Bird Mark 7 Respirator, Monaghan Respirator;
2. Volume constant-pressure variable; Morsch Piston Respirator.



Bennett Respirator

The machines are regulated to give the patient the correct amount of air and oxygen according to sex, size, and the type of disease.

The Bennett and Bird Respirators permit oxygen and air, under a definite pressure, to be passed in and out of the patient's lungs, intermittently. The volume achieved is variable. These respirators are operated by the pressure of the oxygen and air from the tank.

Bird Respirator

Mechanical aspects of these machines are:

Pressure Dials that are read in centimetres of water and have an indicator which fluctuates from zero to the pressure achieved in the patient's lungs.

Expiratory Valve — When the patient breathes out, the air passes out of his lungs through the expiratory valve.

Humidifier — The air which is blown into the lungs is moistened by atomizing it through sterile water in the humidifier.

Air Dilution — It is possible on these machines to dilute the oxygen with air. Thus, 100, 60 or 40 per cent oxygen may be given.

The Monaghan Respirator operates on the same principle, except that it is electric and does not require oxygen, although it can be added if desired.

The Morsch Respirator is electrically controlled. Since it is a volume constant-pressure variable machine, it is regulated to deliver a set volume of air to the lungs intermittently at a variable pressure. This machine also has the pressure dial, expiratory valve and humidifier.

Three methods of attaching these machines to the patient with a leak-proof circuit are:

1. By face mask or mouthpiece and strap,
2. cuffed endotracheal tube,
3. cuffed tracheostomy tubes. These are nylon or rubber James tubes.

Treatment and Nursing Care

There are certain routine measures that are carried out:

History and examination,
frequent chest x-rays,
ventilation measurement,
blood gas measurement,
serum sodium, potassium, chlorides and hemoglobin,
electrocardiogram,
sputum cultures weekly,
new tracheostomy tubes weekly.

In nursing these patients, the nurse must have a full knowledge of the machine being used and must have an alternative method of ventilation available should there be a mechanical failure. She must also know whom to call.

1. *Blood pressure, pulse and respirations* are recorded graphically every half hour. Failure to breathe out enough carbon dioxide because of shallow breathing, shows in an elevation of blood pressure and pulse rate.

2. *Temperatures* are recorded four hourly. They are usually taken rectally.

3. *Suction* routinely: Efficient suctioning is one of the most essential measures carried out in this unit. It is done every half hour, or more frequently if there is copious sputum. The color and amount is important to note. On each period of duty, sterile suction catheters are placed on a sterile tray ready for use. These may be No. 16 and No. 18 rubber Coudee catheters which are hockey-stick shaped and have a terminal opening. They are moistened and inserted into the trachea as far as they will go. The angle tip of the catheter is directed to the left and then to the right in order to suction both lungs. This procedure cannot be overemphasized, as many of the patients cannot cough by themselves.

The mouth and nose may require suctioning also, but with separate catheters of a different type.

4. *Cuffs on tubes* are released at two-hourly intervals to avoid prolonged pressure on the trachea. The cuff is deflated for two to three minutes and then reinflated with a minimum amount of air to prevent any air escaping around the tube. The skin around the tube is cleansed and the gauze bib is changed.

5. *The humidifiers* on the machines should be kept filled with distilled water; they empty in two hours or less.

Humidifier

6. *Hourly turning* — The patients are turned side to back to other side. If they are paralyzed, they are turned in a semi-circular fashion. Some patients require postural drainage.

7. *Physiotherapy* is a most important form of treatment and nurses may assist the therapist. Frequent percussion and shaking are done, followed by suctioning. Passive limb movements are carried out for paralyzed patients.

8. *Eyes* — Antibiotic ointment is used in the eyes of unconscious patients to prevent irritation and corneal ulceration.

9. *Mouth care* is given every two hours for as long as necessary.

10. *Feeding* — Patients who can swallow may have a regular diet; others have intravenous therapy or blender feedings through a gastric tube.

11. *Excreta* — A Foley catheter may be necessary. It is irrigated routinely and changed regularly. Bowel disturbances are common and appropriate measures are taken to relieve them.

12. *Skin care* is an important fea-

ture of nursing care since many of the patients have an excessive amount of perspiration. As well as the daily bed bath, skin care is always given when the patient is turned.

Danger Signs

1. Complaint of shortness of breath, not enough air (the nurse must believe the patient, not just reassure him);
2. cyanosis, restlessness, anxiety, perspiration;
3. pain in the chest;
4. two sides of the chest moving unevenly;
5. headache;
6. dizziness, confusion, depressed level of consciousness;
7. increase in rate of machine;
8. change in blood pressure and pulse rate.

If there is doubt as to whether it is the machine that is at fault, or that it is the patient who is in distress, it is considered that it is the patient, until proven otherwise.

Source of Patients and Transportation

Patients are admitted from both public and private areas of this hospital as well as from other hospitals, both in Toronto and elsewhere throughout Ontario. During transportation, the patients are ventilated by means of a cuffed endotracheal tube and hand ventilation bag, or a portable respirator. They could travel miles by this method.

Future

What began as a four-bed unit has already increased to six beds. Plans are being made to enlarge it to at least 12. The unit is situated in very temporary, cramped quarters. At the beginning, one patient was admitted every ten days approximately; now two patients are admitted approximately every seven days. The increasing demand for this type of treatment is obvious.

The nurse derives much satisfaction from caring for these patients. Because of the number of staff allotted to the unit, there is every opportunity to give complete nursing care and to relieve some of the anxiety that is present in patients who suffer from respiratory insufficiency.

(Continued from page 850)

in Paris, a post that she filled for 40 years. Widely travelled and rich in experience, Mlle de Joannis will be greatly missed in the profession.

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Emma (Lorentz) Edson, a 1900 graduate of the Montreal General Hospital, died in Montreal during April, 1961.

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Averil June Fell, a graduate of Dudley Road Hospital, Birmingham, England and of Queen Charlotte's Hospital, London died in Edmonton on January 7, 1961. She came to Canada in 1957 and was on the staff of the Ottawa Civic Hospital for a short time before accepting a position at the University of Alberta Hospital, Edmonton.

* * *

Virginia Harper, a graduate of Victoria Hospital, London, Ont. died on June 10, 1961, after a long illness. During World War II she served overseas with No. 10 Canadian General Hospital. For the past 16 years she worked as an occupational health nurse at John Labbatt Ltd., London.

Maria Louisa Parker, a graduate of the Montreal General Hospital in 1903, died on June 4, 1961. She was in her 87th year. During World War 1, Miss Parker served with the RCAMC in Canada and partially as an outcome of that experience, conceived the idea of founding a school to prepare trained attendants. The Parker School for Trained Attendants became a reality in 1923. When the school closed in 1947, following Miss Parker's retirement, over 1000 women had received preparation as attendants. The Graduate Nurses' Club, the forerunner of the present M.G.H. Alumni Association, also received its start with Miss Parker's assistance. In recognition of her contribution in this respect and to her profession generally, she was made honorary president of the association in 1954.

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Lena (Mitchell) Weir who graduated from Edinburgh Royal Infirmary in 1918 died in Victoria on June 12, 1961. She was a former director of nurses at the Royal Jubilee Hospital, Victoria, and an honorary member of its alumnae association.

Nursing Referral Programs

KATHLEEN BRADY, M.A.

It is six years since the first nursing referral program in Montreal between the Victorian Order of Nurses, Greater Montreal Branch, and the Montreal General Hospital was put into effect. Since that time a dream of nursing has become a reality.

Planning

IN RETROSPECT, our dream for nursing seemed almost impossible because it involved so many people in a process of change. There was a great deal of administrative detail. Concepts and philosophies that, though not new, had never been used in this country had to be put into practice. Before the referral plan could begin much spade work had to be done between the administration of the VON and the hospital.

A request from the MGH medical team for better liaison between the hospital and the community resulted in many planning conferences between the two agencies. The objective was to bring about improved continuity of nursing care for patients in their homes after discharge from hospital. The questions discussed included: physical facilities, personnel, finances, departmental and interpersonal relationships, referral practice, as well as the whole question of communications. How should the plan be made known and acceptable to the important people — the staff of both agencies?

In the experimental stage it was felt that the nurse acting as liaison could administer the program on a part-time basis. Before the first year ended it was necessary for the nurse to work full-time, with secretarial help. Relief from clerical work allowed time to visit the patients, interview the doctors and nurses on the wards and in the clinics, and attend to planning and implementing the program. Two years ago the nursing referral program was started at the Royal Victoria Hospital, Montreal. With the previous experience gained at MGH and with the help of the hospital personnel, this referral system was set up in a very short time.

The Liaison

The person responsible for liaison is chosen from the staff of the VON This position requires a well-qualified, public health nurse who is familiar with VON policies and practices, hospital procedures and the entire community. An understanding of people and the ability to communicate with them is important. She should also be a skilled organizer in order to implement the mechanics of the system in a smooth and streamlined fashion.

Opinion Study

Before the program at the Royal Victoria Hospital was started the Canadian Nurses' Association, in consultation with the Research and Statistics Division of the Department of National Health and Welfare,[1] did an opinion study of the system at the Montreal General Hospital. General conclusions of the study indicated that the system proved effective because it provided:

a. Specific evaluation of the patient's nursing needs prior to discharge from hospital;

b. continuity of nursing care that is maintained on a highly individual basis.

Communications

As in every smoothly running organization, the opportunity to discuss plans or problems helps to clarify the day-to-day situations that arise. This is done through organized or incidental conferences with the administrator of

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Miss Brady is Assistant District Director, Victorian Order of Nurses, Greater Montreal Branch and Director of the Service described.

[1] *Report of Study of Referral System between Montreal General Hospital and Greater Montreal Branch, Victorian Order of Nurses.* Canadian Nurses' Association, Feb. 1958.

the hospital, the director of nursing, the nurses, the doctors and the social workers. The liaison also attends VON administrative conferences and participates in in-service educational programs.

The different departments in the hospitals play an important part in the program. Without such cooperation the progress and success of these referral systems would be hindered. For instance, the VON liaison has been given full access to the patients' records. As a result, it is necessary to work very closely with the personnel in the record room.

Traditionally, the processing of nursing referrals by the social service department has been the accepted practice. Naturally, one would expect that to bring about change in this area might present some difficulty. Happily, this has not been the case. The social service departments in both hospitals have worked closely with the nursing department to place the administration of nursing referrals where it rightfully belongs — with nursing. However, the two departments are closely allied and concern themselves with exchange of information. Previously, contact with the VON had involved a number of people. Now all communication is done through the VON liaison.

Follow-up

Follow-up in the clinic is an integral part of the referral system. The nurses in the clinics help by making sure that the VON progress reports are seen by the doctors and that the doctors' reports are incorporated in the VON records. This is exacting work but very important.

Education

All new VON staff members spend a half day at one of the two hospitals in order to have some idea of how the system works. As the occasion arises these new nurses are oriented to the program at the district level. The VON liaison is in constant contact with the hospital nurses. She has an excellent opportunity to orient new staff and students, both in and out of hospital. Planned group conferences with her are held periodically. University nursing students and other professional visitors observe the program. They consider this a worthwhile educational experience.

1960 Statistics

The number of referrals processed at the Montreal General Hospital was 742. The number of reports sent from the clinics was 2,588. At the Royal Victoria Hospital, 1,000 referrals were processed and 994 reports were sent from the clinics.

A record is kept of any other contacts made, such as information requested by telephone or in person. These figures stand at 2,391 at the Montreal General Hospital and 1,845 at the Royal Victoria Hospital.

A Practical Example

In order to make this report more meaningful, let us follow a patient who has been on the referral plan since it began at the Montreal General Hospital in 1955.

> Mr. Smith, an alert 79-year-old, has diabetes. Ten years ago, a leg amputation was necessary because of gangrene. Five years later gangrene of the other foot developed and a second amputation seemed probable. He was hospitalized and a trans-metatarsal resection was done. Healing was delayed and there was continuous discharge from the wound.
>
> Before his discharge, the VON liaison was interviewed by the medical team. They stressed the importance of diligent supervision and prompt reporting by the VON.
>
> For five years Mr. Smith was visited in his home and a plan of treatment, teaching and supervision was carried out. Two hospital readmissions were necessary during this time. Each time upon discharge the patient was referred to the VON. The written referral shows only one original referral along with continuation reports of hospitalizations, VON and clinic reports.
>
> For the past two years the wound has been healed. Mr. Smith now visits the clinic only every six months. The visiting nurse sends a progress report every three months to the hospital. She visits Mr. Smith in his home at least once a month. The patient now administers his own insulin and follows his diet well. He is completely independent and is ambulant with crutches. He is part of a warm, happy family life in the home of his married son although the family

is in the submarginal economic group.

It is felt that in this instance a number of the objectives of the referral system have been met.

1. Information was available about the patient: His illness; his care and treatment while in hospital; his reactions and his attitude towards his illness and recovery, the hospital personnel, and his family. This assisted the VON in providing better quality of care in the home.

2. Hospital personnel, especially doctors and nurses, had an opportunity to become acquainted with the community setup. They learned about the services that were available to the patient. Additional information regarding the patient's home, his family, cultural and religious background was made available to the hospital. These factors often have an effect on personal habits and diet and may influence the approach to treatment and supportive care.

3. The patient found that there was no break in his care. Through his contact with the VON liaison in hospital he knew that a nurse in the same uniform would visit him at home and carry out his care just as before. They were able to discuss the plan for his care with his family. Thus the patient and his family became part of the team. They felt secure knowing that this continuity was assured. This is important if the patient and his family are to cooperate and reach maximum independency.

4. The follow-up through the clinic by exchange of reports keeps the doctor informed of the situation in the home and of the patient's progress. The benefits that accrue to the patient from these reports certainly outweigh the time involved in writing them.

5. The hospital, medical and nursing staff was provided with factual information about the facilities in the community. This facilitated the patient's discharge and a much-needed hospital bed was released.

6. An opportunity was provided for student nurses to participate in the total picture of nursing care in the hospital and community. This broadened their basic knowledge and demonstrated the practical application of planned continuity of patient care.

7. The nursing department was provided with an opportunity to follow through the nursing care plan instead of transferring the responsibility to the social service department as in the past. This, in turn, released the social service department from nursing responsibilities for the patient.

In summary, the referral system guarantees superior care for the patient over an extended period.

IN THE GOOD OLD DAYS

(*The Canadian Nurse* — September 1921)

The Cross at Vimy Ridge — Arthur Meighen, Premier of Canada, unveiled the plain war cross erected on the height of Vimy Ridge to the memory of the Canadians who lie there. Fields of growing wheat cover the spot where Canadians stormed the crest of the ridge on April 9, 1917. The children of Arras brought a wreath of red roses and evergreens, the base of the cross being a mass of flowers. Maples shade the graves, brought there that our dead may lie in the shade of the trees of their land.

* * *

It is said that human bones and other objects have been photographed at 250 feet, with a brick and stone wall between the x-ray apparatus and object. There was a four-hour exposure. In 1896 it required eight hours' exposure to photograph, with the plate only ten inches distant.

The authorities of the West End Hospital, London, state that cancer is being successfully treated in that institution by means of an improved application of x-rays. The rays are of a wave-length outside the range of human vision. The highly complex electrical apparatus used was invented by a Bavarian radiologist. It has been carefully tested by experts. The treatment does not injure the patient in the slightest degree, and specialists believe that extraordinary results will be attained in the way of cures.

The Evolution of a Curriculum

JOSEPHINE FLAHERTY, B.SC.N.

In answer to a request for interpretation of the program, we are presenting a report of the progress which was made in the development of the curriculum of the Nightingale School of Nursing, Toronto, during the period from September 1960 to May 1961.

The first tangible achievement of the staff was to formulate a statement of purpose for the school, as follows:

> It is the purpose of the school to conduct a program in basic nursing education, which will prepare nurses who are able to plan, coordinate, and give the care of persons, healthy or ill, in the hospital or in the home.

In the early development of the curriculum, much time was spent in group activity as all members of the staff attempted to agree on a common philosophy and approach. Research and discussion consumed countless hours. Scores of ideas were considered, modified, discarded and re-considered. This kind of activity was a necessary prelude to the actual planning of the curriculum. Throughout the year, similar activity has proved to be essential for continuing development of curriculum content. We have made and will continue to make many modifications, as we carry out plans and evaluate results.

The broad concept of health, as defined by the World Health Organization, human growth and development, and meeting the needs of individuals are the central, unifying themes on which the curriculum is built. Theory is presented in broad units from which principles are evolved. Laboratory experience and supervised practice are integrated throughout. The study of the nurse as a professional person begins with a discussion of the student's concept of a nurse. This concept is broadened to include the three-fold function of the nurse — promotion of health, prevention of disease, and rehabilitation. It is here that the student begins to see the nurse in her different roles, to appreciate the depth of understanding that is required in the nurse and the breadth of opportunity which is available in our profession.

In the first division of the curriculum, which is eight months in duration, attention is focused on the normal, healthy individual. If the nurse is to assist individuals to meet their needs, then she must know what these needs are and how they may be expressed. Hence, early discussions, centred around the needs of all persons, enable the student to recognize and classify needs as physical, emotional, social and spiritual.

The student is introduced quickly to the hospital setting in short, planned experiences with patients. The length and timing of the experience within the patient's day vary with the type of learning situation which is desired. As she spends time with patients, the student begins to develop skills in observation and communication.

The group conference, which is brought into use immediately and used extensively throughout the course, provides opportunity for students to share experiences and has proven very effective as a medium of communication between instructor and student and as a spur to further learning.

In the group conference, the student begins to identify the needs of her patient and attempts to plan ways of meeting them. It is on this basic understanding of needs that a pattern for approaching all nursing situations is built. Thus, from the beginning, the problem-solving approach is used which includes observation and assessment of needs, planning to meet them and evaluation of results.

Through application of her ever-increasing body of knowledge, the student is guided in developing a portrait of her patient as an individual. As she becomes more adept at using

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Miss Flaherty is an instructor in the Nightingale School of Nursing, which is sponsored in Toronto by the Ontario Hospital Services Commission.

problem-solving to develop a plan of nursing, the student is able to apply principles and to extend her range of skills. Instruction in and supervised practice of these skills are planned for the student.

Since self-understanding must precede understanding of others, it is important that the student have time to examine her own behavior and feelings. The instructor makes use of the student's ideas and attitudes to show how individuals are influenced by social environment. A study of various factors in the social environment assists the student to understand and accept the values, beliefs, and attitudes of the persons with whom she will be working.

In examining the ways in which the family and community are organized to meet needs, the student begins to appreciate the roles of many persons and groups in supporting individuals. Here, for instance, she sees the hospital as one of many agencies which supports health needs.

The evolution of nursing and its relationship to other professions are studied. Communication with other workers is planned from the beginning of the course. Thus, the student is helped to assess her role as a member of the health team.

Emotional needs are studied in considering the growth and development of the healthy person through the various ages and stages. The importance of spiritual needs and the nurse's role in helping to meet these are examined and discussed. The study of scientific facts and principles which are fundamental to nursing provides the basis for understanding of physical needs. Basic knowledge of anatomy, physiology, chemistry, physics, bacteriology, nutrition and pharmacology is presented in a broad science course and is correlated with other learning.

At the end of two or three months, the student begins a series of visits to the community, where she is able to observe persons in the various settings and the situations in which they function. The home visit provides opportunity to see family groups. The school, the community centre, the occupational centre and the club for older age persons provide for observation of varying age groups, activities and behavior patterns. Group conferences, following each observation visit, help to enlarge the student's understanding of relationships and cultural influences, and provide further opportunity for her to develop observation and communication skills.

Toward the end of this first division, which is concerned with the normal, healthy individual, the student has concentrated experience in the obstetrical unit. This gives her the opportunity, for an extended period of time, to identify and assist in meeting the needs of healthy mothers and babies. Nursing care plans, of which health teaching is an important feature, are developed. Here, the student draws on her knowledge of growth and development, physical, emotional and social needs, to assist her in recognizing the beginnings of mother-infant relationships and in appreciating the effects of a new member on the organization of the family.

The second division of the course, which is ten months in length, is concerned with deviations from health in children and adults. Here, the student applies the problem-solving approach to identify and meet the modified needs of persons during illness.

The area of deviations from health is introduced by a review of the concept of homeostasis and by discussion of various factors which may affect homeostasis. Subsequent teaching is centred around basic needs and how disease processes such as trauma, invasion by foreign materials, neoplasms, degenerative and metabolic disturbances, congenital anomalies and psycho-social disorders may modify these needs.

Students apply their knowledge of growth and development, the normal function of the human body, and the resources which are available in the family and community, to formulate and apply principles and on this basis to plan nursing care, of which rehabilitation and health teaching are integral parts. Care is planned around the total needs of the individual with the aim of assisting with the therapeutic and rehabilitative measures which are coordinated by all members of the health team. Concurrent learning experiences and supervised practice are planned in various clinical areas to meet the educational needs of the student.

A four-month, final division of the course, which is still in the process of development, will include study of major health problems, and further consideration of planning the care of individuals in the hospital and in the home.

The total program is designed to provide experience for the students which will assist them in developing further understanding of, and convictions about, the privileges, duties and responsibilities of intelligent citizenship and professional membership. Each student is expected to participate actively in all phases of the course and to use self-directed study as a means of learning. Through the operation of the Student Organization, which has been developed by the students, regulations for residence life are formulated and carried out by the members.

Throughout the curriculum, continuing emphasis is placed on problem-solving, application of principles and development of skills. The extensive use of conference and group discussion, of planned observation and written report and of the situation-type assignment, has been of particular value in developing the student's skill in observation and communication.

Weekly communication between staff members and participation by all instructors in clinical experience provide for carry-over and application of knowledge from each course to the others. This assists students to broaden their understandings and to integrate their learning.

Resource persons are used, at the discretion of the staff, for consultative purposes and to assist in carrying out the teaching program. The extent and nature of their contributions are determined by the school.

A complete picture of the program is not possible in a discourse of this nature. We hope that we have provided some interpretation of what we are trying to accomplish and some indication of how we have gone about doing so.

Our first year has been stimulating and we have learned a great deal. We derive our satisfactions as we watch our students grow and develop. We look forward to our second year as an equally challenging experience.

Book Reviews

Golden Age of Quackery by Stewart H. Holbrook. 302 pages. Brett-Macmillan Limited, 132 Water St. S., Galt, Ont. 1959. Price $4.95.
Reviewed by Mrs. Ann Wardrop, 5288 O'Bryan Ave., Montreal.

The author has written a fascinating story of the heyday of patent medicines and of the remarkable people who capitalized on the gullibility of the public. It begins with a crusading reporter, Samuel Hopkins Adams, whose series of articles in a national magazine exposing "The Great American Fraud" precipitated the passage of the Pure Food and Drug Act.

From this point, the story ranges back to 1692 when an advertisement for "That excellent Antidote against all manner of Gripings called Aqua anti tanminales" was printed. It covers the intervening centuries up to the present where the merits of Dr. Pierce's Golden Medical Discovery may still be seen displayed on a good many barns. Mr. Holbrook explores the realm of electric and magnetic therapy, quack doctors, medicine shows and the "healers". He pictures the amazing ingenuity of the men and women who profited in these lines of endeavor.

This most interesting book will appeal to anyone who has ever marvelled at the long and lucrative life of patent medicines.

Premature Babies by A. K. Geddes, M.D. 215 pages. W. B. Saunders Company, 3207 West Washington Square, Philadelphia. 1960. Price $4.50.
Reviewed by Miss Margaret M. Madden, School of Nursing, University of Alberta, Edmonton.

In the preface the author states what he intends to accomplish, which is to describe what should be done for premature infants, and to explain the reasons. Throughout the text this intention is closely followed.

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In the first chapters intrauterine existence with emphasis on the efficiency of the placenta is considered. This is followed by birth and the first 15 minutes of life. An appraisal of the infant by the nurse is given in full and some details of the nursing care. The succeeding chapters give a description of possible complications in the condition of an infant. Sufficient anatomy and physiology is included for adequate understanding.

Finally some of the nursing techniques and the drugs that may be ordered are considered. These two chapters might have been placed after Chapter Five in which nursing care is discussed. The suggested floor plan and list of equipment would be helpful to anyone responsible for planning a nursery. The book ends with a description of the care of an infant in a home and a consideration of prematurity as related to public health.

Although this book was written by a doctor, it is definitely for nurses. It will not only meet the needs of the nurse working in a nursery for premature babies but it will also encourage her to know and to observe more effectively. It would serve as a text for nurses doing postgraduate study in this area, and as a valuable addition to the library of a nursery and a school of nursing.

Nutrition and Family Health Service by Linnea Anderson and John H. Browe, M.D. 287 pages. W. B. Saunders Company, 3207 West Washington Square, Philadelphia. 1960. Price $5.00.
Reviewed by Sister Joan Mary, Charlottetown Hospital, Charlottetown.

The objective of this book is to provide a broad general knowledge of nutrition for the public health nurse. It has been designed to present and develop concepts within the framework of guidance and counselling for families in relation to their nutritional needs and modifications of their food practices to meet these requirements.

A knowledge of food and nutrition is not the *only* factor in a health program, but dietary principles are of such importance that they cannot be ignored. They are especially significant to the public health nurse whose duty it is to relate food and family meals to the nutritional needs of all age groups.

Section one provides an orientation to "Man and his Food." Nutritional needs and foods as sources of nutrients are presented as a body of knowledge essential to the understanding of health problems. *Section two* presents an analysis of the life cycle and the nutritional requirements of various age groups. *Section three* discusses modification of present food practices to meet specific therapeutic needs. In addition, it includes "The Exchange System" for calculating diabetic diets and an analysis of the "low sugar bar." It is important for the nurse to realize that substitutions in diet can be very complicated for the average person.

The text is a source of authoritative information. It is worthy of inclusion in the library of the public health nurse and of those who have a professional knowledge of nutrition.

Rehabilitation a manual by Mildred J. Allgire and Ruth R. Denney. 61 pages. Springer Publishing Company, Inc., New York. 1960. Price $1.25.

Reviewed by Mrs. Marilyn Marsh, Director of Nursing Services, Sunshine Camp Children's Rehabilitation Centre, St. John's, Nfld.

The purpose of this manual is to outline teaching methods for a program of basic exercises and daily activities to aid in the restoration to the fullest possible potential of a disabled person. It explains the principles involved it its application in any situation, including the hospital, home and on the job.

The authors stress the extreme importance of early recognition of deformity and disability. The value of adequate preventive measures and good follow-up care is emphasized.

The manual is well written, easy to understand. The illustrations are excellent. The range of motion exercises are particularly well described. As the title implies, the nurse *could* give and teach rehabilitation with the help of this manual. It would also be valuable to the disabled person himself, or to his family.

Diabetes Mellitus by Marguerite M. Martin, R.N. 167 pages. W.B. Saunders Company, 3207 West Washington Square, Philadelphia. 1960. Price $3.50.

Reviewed by Miss Shirley Biccum, Medical Clinical Instructor, Grace Hospital, 200 Arlington St., Winnipeg.

In the preface, the author states her purpose. "I have endeavored to write a handbook for nurses which will be complete in all phases of diabetes. I have tried to make the scope of the discussion sufficiently broad so that nurses in the various fields of nursing will benefit."

The text covers all phases of diabetic care simply but thoroughly. Good detail is given in the chapters on exercise and instruction of the diabetic. Suggestions for use in teaching persons with addtional problems, such as defective vision and hearing, are included. Up-to-date information is given about the new oral hypoglycemic compounds — their uses, reactions and contraindications.

Complications in diabetic care, such as surgery, pregnancy and diabetes in children, are fully covered. There are suggestions for helping the traveller, the night worker and the diabetic who is ill at home. References are given at the end of many chapters for nurses wishing to delve more deeply into some topics.

This is an easily read book but one which does not sacrifice detail. It would be equally valuable to the student nurse, the general duty nurse or the public health nurse. In fact it would be an asset wherever nurses care for diabetic persons.

Pediatric Nursing by Gladys S. Benz, R.N., M.A. 572 pages. The C.V. Mosby Company, St. Louis, Mo. 4th ed. 1960. Price $6.00.

Reviewed by Mrs. A. Game, Clinical Instructor, The Children's Hospital, Winnipeg 3.

This edition, like the previous ones, centres attention on "the child as an individual and as a member of the family and of the community." All phases of the child's development, physical, mental, social and emotional are taken into consideration. They are discussed in relation to the well and the sick child. In the discussion of disease conditions, emphasis is placed on the manner in which illness affects the child's development.

The subject material is well presented. More illustrations, could be used advantageously. The unit on "The Child in the Community," while interesting, is not particularly useful to the Canadian nurse.

The text would be good reference material for both student nurses and their instructors.

Varied Operations by Hon. Herbert A. Bruce, M.D., F.A.C.S., L.R.C.P., F.R.C.S. 366 pages. Longmans, Green and Company, 20 Cranfield Road, Toronto 16, 1958. Price $6.00.

Reviewed by Mrs. Ann Wardrop, 5288 O'Bryan Ave. Montreal 28.

Dr. Bruce notes in the beginning that he has written this book for his grandchildren. It is a very personal account and one that would appeal primarily to members of his family and intimate friends.

There is little concerning actual medical practice. The story deals mainly with the author's successes in many other fields, notably as Lieutenant Governor of Ontario, founder of the Wellesley Hospital and as professor of surgery at the University of Toronto. He was a Conservative member of Parliament from 1940-46 during the time of the conscription crisis, the Baby Bonus and the preliminaries of a national health scheme. His views on these and other issues are most enlightening. Naturally they will tend to be the direct opposite to those with a Liberal inclination.

On the whole I found this autobiography with its recital of names and anecdotes concerning emminent and titled persons rather dull. There is the occasional bright spot that gives the reader hope of something better but the book soon returns to its list of names and places.

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Registered Nurse (1) for General Staff Duty for 3 mo. interval (replacement of regular Reg. N.) for 42-bed hospital (3 M.D.'s) Farmland area. AARN policy in force. Living-in facilities. Please apply: St. Joseph's Hospital, Galahad, Alberta.

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General Duty Nurses (2) for 31-bed hospital situated in the Scenic Fraser Canyon. Salary: $280 unregistered; $300 registered. Nurses' Home. M.S.A. Please apply giving qualifications, etc. to: Administrator, St. Bartholomew's Hospital, Lytton, British Columbia.

General Duty Nurses. Starting Salary: $297 for Registered, $282 for Non-Registered with yearly increments. 4-wk. vacation, all statutory holidays with pay. Group medical insurance, superannuation plan. Nurses' home available. Apply: Director of Nurses, Nicola Valley General Hospital, Merritt, British Columbia.

General Duty Nurses for new 82-bed hospital in the Aluminum City. Salary $312-$374, 40-hr. wk., 9 statutory holidays, 28 days vacation, 1½ days sick leave per mo., accumulative to 60 days. Residence available $45/month. Experience, "On Call" & postgraduate increments. 50% medical care plan paid. Superannuation. Apply: Director of Nursing, General Hospital, Kitimat, British Columbia.

General Duty Nurses for 110-bed hospital in northwestern B.C. Salary—non-registered $297, B.C. registered $312-$374. Travel allowance, newly furnished residence available. For full details contact: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

General Duty Nurse for well-equipped 80-bed General Hospital. Initial salary $307, maintenance $47.50. 40-hr. 5-day wk., 4-wk. vacation with pay. Apply: Sacred Heart Hospital, Smithers, British Columbia.

General Duty Nurses for modern 154-bed General Hospital. Basic salary $297, generous personnel policies, nurses' residence. Apply to: Director of Nurses, Trail-Tadanac Hospital, Trail, British Columbia.

General Duty Nurses: starting salary $299 if 2 yr. experience, $285-$342 in 4 yr. Non registered $270. Maintenance $50, 10 statutory holidays, 4-wk. annual vacation. 1½ day sick leave per mo. Very active town, world famous Cariboo cattle country, annual stampede. Apply: Director of Nursing, War Memorial Hospital, Williams Lake, British Columbia.

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(4) Regional Superintendent, 705 Commercial Building, 169 Pioneer Avenue, Winnipeg 1, Manitoba.
(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.
(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.
(7) Zone Superintendent, P.O. Box 430, Upper Town, 3 Buade Street, Quebec 4, P.Q.
(or) Chief, Personnel Division,
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Registered & Licensed Practical Nurses. Salary rating for Registered Nurses min $285 - max. $319 per mo. with $10 additional for evening duty. For Licensed Practical Nurses min. $218 - max. $242 per mo., 8-hr. duty (day, evening or night), 40-hr. wk., living accommodation available. Apply in writing to the Personnel Office, Winnipeg Municipal Hospitals, Morley Avenue East, Winnipeg 13, Manitoba.

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Matron for 14-bed hospital, general service, limited surgery, RNA salary scale, room, board & laundry $35 per mo. Experience in supervisory capacity essential. Travelling expenses paid from Maritime points. Grand Manan Hospital, North Head, New Brunswick.

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Nursing Supervisors, Head Nurses, General Duty Nurses for new 150-bed Chronic & Convalescent Hospital (to open approx. Sept. 1, 1961). Excellent salary schedule, liberal vacation policy & fringe benefits. Apply to: Administrator, Chronic & Convalescent Hospital, Fort William, Ontario.

Nursing Supervisor for 100-bed accredited active hospital. Further particulars available from: The Director of Nursing, North Bay Civic Hospital, North Bay, Ontario.

Supervisor T.S.O. (Nursing Service) for 106-bed hospital. Residence accommodation available. Apply stating qualifications & experience to: Director of Nursing, Norfolk General Hospital, Simcoe, Ontario.

The Toronto Psychiatric Hospital — Applications are invited for the post of **Superintendent of Nurses** — Salary: $4,600 to $5,750 with Civil Service benefits (Provincial Dept. of Health). The incumbent will be expected to develop psychiatric nursing services in an expanding Hospital-University organization. The hospital is a teaching hospital of the University of Toronto Medical Faculty. Psychiatric nursing education both undergraduate & graduate is an emphatic responsibility requiring high qualifications & experience. Apply before Nov. 1st, 1961, to: Director, Ontario Hospitals, Parliament Buildings, Toronto, Ontario.

Head Nurse for Newborn Nursery — previous supervisory experience — postgraduate study desirable — attractive personnel policies. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

Assistant Head Nurse (immediately) for 50-bed Surgical Unit in modern 162-bed hospital. Starting salary commensurate with qualifications & experience. Hospitals of Ontario pension plan, excellent personnel policies. Stratford is a delightful city of 20,000, within easy reach of larger centres. Applications, stating qualifications & experience to: Director of Nursing, General Hospital, Stratford, Ontario.

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McKellar General Hospital, Fort William, Ontario invites applications for: (1) **Clinical Instructor** for medicine (2) **General Staff,** all services, including operating room. Basic Salary: $285 to $325 per mo. with Ont. registration. Apply to: The Director of Nursing.

Registered Nurses for expanding General Hospital, Medical, Surgical, Operating Room & Obstetrical services, at Ajax, Ontario on Highway 401, 20-mi. east of Toronto, hourly bus service to hospital. Salary in accordance with qualifications & experience, increments every 6-mo., sick & vacation time after 6-mo., sick time cumulative to 14 days, 37½-hr. work wk., pension plan, living in accommodation. Apply to: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario. **Nurses from Europe & United Kingdom,** apply to: Canadian Department of Labor, 61 Green Street, London, W.1, England.

Registered Nurses (September & November) for 19-bed General Hospital increasing to 25-beds this summer. Basic salary $300, room & board $30 in modern residence — single rooms. 6-monthly increments. For further particulars write: Miss J. Scollie, Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario.

Registered Nurses $300 per mo. min. to max. $340, 3-weeks vacation with pay, sick leave after 6-mo. service. Non Registered — $15 less, Cert. N.A. $210 min to max. $240, 2-wks. vacation with pay, Non Certified N.A. $200 to max. $230. Increases for both groups $10 per mo. after 1-yr. on staff. 9-statutory holidays. All staff:— 5-day 40-hr. wk. Apply: Superintendent, Englehart & District Hospital, Inc., Englehart, Ontario.

Registered Nurses for 95-bed General Hospital in attractive town on Lake Huron in a vacation resort area. Good personnel policies & 40-hr. wk., Residence accommodation available. Apply to: The Director of Nursing, Alexandra Marine & General Hospital, Goderich, Ontario.

Registered Nurses Applications & enquiries are invited for General Duty positions on the staff of Manitouwadge General Hospital. Modern, well-equipped 33-bed hospital in new mining town, about 250-mi. East of Port Arthur & North-West of White River, Ontario. Excellent salary & fringe benefits, liberal policies regarding accommodation & vacation. Population 2,500. Nurses' residence comprises individual self-contained appartments. Apply, stating qualifications, experience, age, marital status, phone No. etc., to: The Administrator, General Hospital, Manitouwadge, Ontario. Phone TAylor 6-3251.

Registered Nurses (General Staff) for 100-bed accredited active hospital. Salary: $280-$310 per mo. with semi-annual increments. Good personnel policies. Please apply: The Director of Nursing, North Bay Civic Hospital, North Bay, Ontario.

Registered Nurses for 60-bed hospital. Salary $280 per mo. gross. Good personnel policies. For further particulars apply: Superintendent, St. Marys Memorial Hospital, St. Marys, Ontario.

Registered Nurses, Certified Nursing Assistants for modern 75-bed hospital. Starting salary: R.N.'s $300 per mo. with merit increases after 6-mo. service, C.N.A.'s $216 per mo. Single room residence accommodation available. Attractive growing town of 5,500 midway between Winnipeg & Fort William on the main line of the C.P.R. on the Trans-Canada Highway in the midst of large tourist area. For information regarding personnel policies, community activities, etc. please write, wire or telephone to: The Director of Nursing, District General Hospital, Dryden, Ontario.

Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $300 & $210 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. Hospitals of Ontario pension plan. Residence accommodation available. Assistance with transportation can be arranged. Apply: Director of Nurses, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R.N. salary $305-$352. 28-day vacation after 1-yr. C.N.A. salary $221-$252, 2-wk. vacation after 1-yr., 3-wk. after 2-yr. Credit for past experience, $5.00 increment every 6-mo., 40-hr. wk., 8 statutory holidays. Room & bard $45.00 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

Registered Nurses & Certified Nursing Assistants (September 1st. or sooner) for 100-bed active General Hospital in Ottawa Valley. 45 additional beds opening late summer, 4-hrs. from Montreal, 2-hrs. from Ottawa, excellent train & bus service, 8-mi. from Camp Petawawa. Personnel policies include 5-day wk., 7 statutory holidays, 1¼-days sick leave cumulative to 60-days after 6-mo., 3-wks. vacation after 1-yr., employer participation in pension plan. Make application to: Miss E. Sheppard, Reg.N., Director of Nursing, Cottage Hospital, Pembroke, Ontario.

Registered or Graduate Nurses for modern 100-bed hospital, 40-hr. wk., rotating shifts, good location near Rideau Canal Summer Resort, 1-hr. from Ottawa, for further details apply: Director of Nursing, Public Hospital, Smiths Falls, Ontario.

Registered Nurses for General Duty in all departments including premature & new-born nursery, Isolation, Emergency & Recovery Room. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

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Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $285 per mo.** with annual merit increments, **plus annual bonus plan.** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. All patients' services in new modern building opened in November 1960. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

Registered Staff Nurses for Operating Room Department: A new well equipped unit; rotating hours of duty; attractive personnel policies. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto, Ontario.

General Duty Registered Nurses (2) for 32-bed hospital. Excellent salary & personnel policies. Living accommodation. Apply: Administrator, General Hospital, Atikokan, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $285, Excellent personnel policies, pension plan, residence accommodation. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for modern 100-bed hospital with building program just completed. Registered start at $285 monthly, Graduates at $250; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. Opportunities for O.R. work. Busy hospital located near Point Pelee National Park, short drive from Detroit, Michigan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

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General Duty Nurses for 350-bed General Hospital located in downtown Toronto — Rotating hours of duty, attractive personnel policies, in-service education program. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. 40-hr. wk., 8 statutory holidays, full particular, apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.

General Duty Nurses & Certified Nursing Assistant for modern 50-bed active hospital, 40-hr. wk. with all statutory holidays, pension plan & sick leave benefits. Meaford is situated on Georgian Bay & is an all year resort town. For further information apply to: Director of Nursing Services, General Hospital, Meaford, Ontario.

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Public Health Nurse (Qualified) for generalized P.H. nursing program. Minimum salary: $3,700, annual increments, salary range according to experience. Car allowance: $30 per mo; pension plan, other benefits Windsor Medical, Ontario Hospitalization. 4-wk. vacation after 1 yr., all statutory holidays, sick leave. Apply to: M. Mackenzie, Chatham Board of Health, Chatham, Ontario.

Public Health Nurses required by Stormont, Dundas & Glengarry Health Unit for generalized program in Seaway Development Area, usual benefits, liberal car allowance, pension plan, allowance for experience. Apply to: Dr. Paul S. deGrosbois, Medical Officer of Health, Health Unit, 26 Pitt Street, Cornwall, Ontario.

Public Health Nurse will be required by the Kitchener Department of Health in September 1961. For further information write: Miss Olga Friesen, Department of Health, 233 Queen Street South, Kitchener, Ontario.

Public Health Nurse for City of London, Must have Public Health nursing degree. Full civic benefits. Salary dependent on experience & qualifications with range from $3,530 yearly. Address all correspondence to: W. J. Anthony, Personnel Director, City Hall, London, Ontario.

Public Health Nurses (Qualified). Salary $3,900 - $4,875, annual increment $195. 5-day **wk.,** transportation provided, the usual employee benefits. Apply: Dr. C. C. Stewart, Medical Officer of Health, 50 Centre Street, City Hall, Oshawa, Ontario.

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Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, ear, eye, nose & throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Nurses (2) for United Church Mission Hospital in northern B.C. Salary: $305 per mo. An opportunity for Christian service. Apply: Wrinch Memorial Hospital, **Hazelton, British Columbia** or Dr. M. C. Macdonald, Board of Home Missions, United Church, 85 St. Clair Ave. East, **Toronto, Ontario.**

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Psychiatric Nursing Instructor for Mental Hospital conducting basic undergraduate 12-wk. course for affiliate students of nursing. Usual Civil Service benefits. For details apply: Director of Nursing Education, Hillsborough General Hospital, P.O. Box 4000, Charlottetown, Prince Edward Island.

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Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda.

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Directress of Nursing. Should have some previous experience in administration of small or large hospital, & be at least partially bilingual. Salary range: $425 to $460 per mo. depending on experience & qualifications. Please address all inquiries directly to: Medical Director, Boisvert Memorial Hospital, P.O. Box. 310, Baie Comeau, Quebec.

Assistant Head Nurses; excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurses for 30-bed General Hospital, 50-mi. from centre of Montreal, excellent bus service. Starting salary $275 per mo., 3 semi-annual increases, 40-hr. wk., 4-wk. annual vacation, statutory holidays, 2-wk. sick leave, Blue Cross paid, living accommodation available. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

Registered Nurses & Certified Nursing Assistants for modern 60-bed General Hospital, salary $275 per mo. 5 semi-annual increases; 40-hr. wk., 4-wk. vacation. Cert. N.A. starting salary $200, 3-wk. vacation. Accommodation available in new motel-style nurses' residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

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Registered Nurses (2-immediately) for 160-bed modern hospital. Salary: $280-$355. 40-hr. wk., 21-28-day vacation, 10 statutory holidays. Good personnel policies. Comfortable living accommodation available in the city. Good orientation & in-service educational program. Good recreational facilities. Meals may be taken at the hospital cafeteria. 50 cents differential for each 8-hrs. of evening & night rotation. Apply to: Sister Anne of the Sacred Heart, Director of Nursing, Notre Dame Hospital, North Battleford, Saskatchewan.

General Duty Nurses for 8-bed hospital. Basic salary $290, personnel policies as SRNA. Apply to: Matron, Union Hospital, Rockglen, Saskatchewan.

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Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

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REGISTERED NURSES (2 OR 3) for **General Duty** for 80-bed modern hospital in Imperial Valley, Calif. Air conditioned hospital & attractive nurses' residence. Salary comparable to other parts of country. Please apply: Administrator, Pioneers Memorial Hospital District, Route 1, Box 70, Brawley, California.

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Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary $350 with range to $390 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

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Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered General Duty Nurses (3) for small General Hospital. Starting salary: $350-$400 after 1st year. Furnished apt. available. Apply by writing: Box 336, **Dos Palos, California,** or phone collect: Express 2-3450 after 6 p.m.

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Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Duty Nurses for 72-bed hospital located in college town in mountainous portion of Colorado. Salary $350 per mo. with periodic increases, fringe benefits — including meals, sick leave, vacation, etc. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered Nurse (immediate position on staff) for new 150-bed hospital. Immediate California registration available. Write: Director of Nursing, Little Company of Mary Hospital, Torrance, California.

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Registered General Duty Nurses for 200-bed General Hospital. Located along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $380 for days, $410 for evenings, $400 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Illinois.

Operating Room Nurses (Days & P.M.) 200-bed General Hospital located along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $405 days, $435 evenings, $425 nights, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Operating Room Supervisor for 134-bed JCAH accredited hospital. Advanced preparation for this specialty required. Emergency room & recovery room included in area of responsibility. Pleasant lake shore community. Salary commensurate with experience. Write: Harold MacKinnon, R.N., Director of Nursing Service, City Hospital, Holland, Michigan.

Nurses — The oldest hospital in Minneapolis, now located in a totally new, completely air-conditioned 306-bed building, has openings in all services. Hospital has approved internship & residency program, plus accredited school of nursing. Excellent facilities, wonderful climate, still close to your home. Starting salary in accord with contract agreement with Minnesota Nurses' Association. Tenure increases. Liberal vacation & sick leave program. For further information contact: Director of Personnel, St. Barnabas Hospital, 714 Ninth Avenue South, Minneapolis, Minnesota.

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Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Registered Nurse (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $372. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon.

Graduate Nurses (Professional) We are an established teaching hospital offering a variety of interesting assignments in patient-centered care. The current starting salary for Staff Nurse is $390 per mo., for evenings & nights $410 per mo., for a 40-hr. 5-day wk. Fringe benefits include paid vacation up to 4 wks. per yr., 8 paid holidays per year, cumulative sick leave, Blue Cross & pension plan available. The hospital is centrally located & offers private room accommodations in our modern nurses' residence. Your inquiries are invited: Director of Nursing Service, Department C.J.N., Mount Sinai Hospital of Chicago, 2750 West 15th. Place, Chicago 8, Illinois.

Staff Nurses (All Clinical Services) Base salary $319, differential for 3-11 and 11-7 shifts, liberal personnel policies include sick leave, retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs — housing available on campus or in vicinity of hospitals. Apply: Director of Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

ONTARIO

Staff Nurse for newly formed County Health Unit. Immediate employment. Salary schedule $3,900 min., $4,875 max., annual increments $195. Basic car allowance $45 per mo., plus 5¢ per mi. Pension & generous fringe benefits & holiday plan. Please apply giving qualifications & experience to: Charles H. A. Stager, Secretary-Treasurer, c/o Court House, 20 Weber Street East, Kitchener, Ontario.

THE MONTREAL CHILDREN'S HOSPITAL

INVITES APPLICATIONS FROM

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2. **Male Trained Attendants** — to fill vacancies in a newly created Adolescent Unit and in the Psychiatric Unit.
3. **Pediatric Clinical Instructors** — must have Pediatric experience and at least a diploma from a recognized university.

Apply in writing to:

DIRECTOR OF NURSING, THE MONTREAL CHILDREN'S HOSPITAL,
2300 TUPPER STREET, MONTREAL 25, P.Q.

CHILDREN'S HOSPITAL OF WASHINGTON, D.C.

OFFERS

Registered Nurses a 16-wk. supplementary program in pediatric nursing. Admission dates, January 3, May 2, August 29, 1961; January 3, May 8, 1962.

For complete information write to:

DIRECTOR OF NURSING, 2125-13th STREET, N.W., WASHINGTON 9, D.C.

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for

Registered Nurse desirous of owning what is considered the most beautiful licensed Nursing Home in Niagara Peninsula. Business is well-established and profitable. Owner selling due to ill health. Phone Fruitland TW4-1342 for appointment.

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required for 64 bed Tuberculosis Section of
MANITOBA REHABILITATION HOSPITAL
to be appointed November 1st, 1961.

Please apply to:

DIRECTOR OF NURSING SERVICES, SANATORIUM BOARD OF MANITOBA,
1654 PORTAGE AVENUE, WINNIPEG 12, MANITOBA

CANORA UNION HOSPITAL

Canora, Sask.

requires

1. Instructor for Nursing Assistants, duties to commence in December, 1961.
2. General Duty Nurses — for all departments.

For further information, apply to:

DIRECTOR OF NURSING,
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BRANDON GENERAL HOSPITAL

Now in construction of a new
220 bed hospital with
School of Nursing - 60 students

REQUIRES

ASSISTANT DIRECTOR OF NURSING SERVICE

For further information please write to:

PERSONNEL OFFICER
BOX 280,
BRANDON, MANITOBA

General Duty & Operating Room Nurses for 210-bed General Hospital. Start $335 days, $360 evenings, $355 nights, plus $10 for O.R., university city, 40-hr. wk., 7 holidays, extended vacations, sick leave benefits, free Blue Cross hospital-medical insurance & $2,500 life insurance, retirement program plus Social Security, extensive Intern-Resident Educational Program, living quarters available. Write, Personnel Manager, Virginia Mason Hospital, 1111 Terry Avenue, Seattle 1, Washington.

REGISTERED NURSES (2 OR 3) for **General Duty** for 80-bed modern hospital in Imperial Valley, Calif. Air conditioned hospital & attractive nurses' residence. Salary comparable to other parts of country. Please apply: Administrator, Pioneers Memorial Hospital District, Route 1, Box 70, Brawley, California.

Registered Nurses, Therapists, X-ray Technicians & Laboratory Technicians. El Camino Hospital, 307-beds, *opening September 1, 1961, now accepting applications. Location,* Mountain View — Los Altos — Sunnyvale area, 35-mi. south of San Francisco & 10-mi. north of San Jose. There are 3 colleges within 15-min. of the hospital — Stanford University, Santa Clara University, & San Jose State College. Write: Director of Personnel, El Camino Hospital, 2500 Grant Road, Mountain View, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary $350 with range to $390 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

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Registered Nurses for private 258-bed hospital for men, women & children. Staff Nurse salaries from $345 - $415, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

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Registered General Duty Nurses (3) for small General Hospital. Starting salary: $350-$400 after 1st year. Furnished apt. available. Apply by writing: Box 336, **Dos Palos, California,** or phone collect: Express 2-3450 after 6 p.m.

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Staff Nurses for 200-bed General Hospital in the heart of Los Angeles cultural & educational center. General Duty $350 per mo., min. days; $35 differential for 3-11 & $30 differential for 11-7. Time and ½ over 40-hr. wk., social security, state disability insurance, 2-wks. vacation end of 1-yr., 3-wks. after 5-yrs., 7 paid holidays, 12-days sick leave. Cotton uniforms laundered, nurses' residence $10 per mo. Graduates of accredited schools, California license obtainable immediately. Promotions made from staff whenever possible. Apply: Mary Topper, R.N., Director of Nurses, Santa Fe Hospital, 610 South St. Louis Street, Los Angeles 23, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Duty Nurses for 72-bed hospital located in college town in mountainous portion of Colorado. Salary $350 per mo. with periodic increases, fringe benefits — including meals, sick leave, vacation, etc. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered Nurse (immediate position on staff) for new 150-bed hospital. Immediate California registration available. Write: Director of Nursing, Little Company of Mary Hospital, Torrance, California.

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Vacancies are available for selected STATE REGISTERED NURSES who desire to undertake private nursing on the basis of fees recommended by The Royal College of Nursing.

The Institute, established for over 50 years as a non-profit making venture, offers nurses the advantage and comfort of facilities at its premises; also board and residential accommodation at moderate prices.

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With postgraduate preparation required for modern, 130-bed chest hospital. Student affiliation and in-service program. Good personnel policies. Salaries commensurate with experience and education.

Apply:

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MANITOBA REHABILITATION HOSPITAL

158 beds for Physical Medicine and Rehabilitation,
64 beds for Tuberculosis. Opening early 1962

Requires a

Director of Nursing

To be appointed, January 1st, 1962

Please apply to:

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SANATORIUM BOARD OF MANITOBA
1654 PORTAGE AVENUE, WINNIPEG 12, MANITOBA

THE HAMILTON GENERAL HOSPITALS

invites applications for

HEAD NURSES AND ASSISTANT HEAD NURSES

MEDICAL AND SURGICAL WARDS

GOOD PERSONNEL POLICIES

Apply to:

THE DIRECTOR OF NURSING, HAMILTON GENERAL HOSPITAL,
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Registered General Duty Nurses for 200-bed General Hospital. Located along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $380 for days, $410 for evenings, $400 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Illinois.

Operating Room Nurses (Days & P.M.) 200-bed General Hospital located along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $405 days, $435 evenings, $425 nights, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Operating Room Supervisor for 134-bed JCAH accredited hospital. Advanced preparation for this specialty required. Emergency room & recovery room included in area of responsibility. Pleasant lake shore community. Salary commensurate with experience. Write: Harold MacKinnon, R.N., Director of Nursing Service, City Hospital, Holland, Michigan.

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COURSES FOR R.N.'S N.Y. POLYCLINIC MED. SCH. & HOSP. — in heart of Manhattan — 6 mos. courses in: O.R. NURSING, OPD. NURSING, MED.-SURG. NURSING. Classes 4 times yrly: Mar., June, Sept., Dec. Room, meals, Medical Care & monthly cash stipend. Positions available to graduates of our Courses. For information write: Director of Nursing Education, 345 W. 50 St., N.Y.C., NEW YORK.

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THE MONTREAL CHILDREN'S HOSPITAL

INVITES APPLICATIONS FROM

1. **Registered Nurses** — to fill vacancies both on the wards and in the Operating Room
2. **Male Trained Attendants** — to fill vacancies in a newly created Adolescent Unit and in the Psychiatric Unit.
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Apply in writing to:

DIRECTOR OF NURSING, THE MONTREAL CHILDREN'S HOSPITAL,
2300 TUPPER STREET, MONTREAL 25, P.Q.

CHILDREN'S HOSPITAL OF WASHINGTON, D.C.

OFFERS

Registered Nurses a 16-wk. supplementary program in pediatric nursing. Admission dates, January 3, May 2, August 29, 1961; January 3, May 8, 1962.

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DIRECTOR OF NURSING, 2125-13th STREET, N.W., WASHINGTON 9, D.C.

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Registered Nurse desirous of owning what is considered the most beautiful licensed Nursing Home in Niagara Peninsula. Business is well-established and profitable. Owner selling due to ill health. Phone Fruitland TW4-1342 for appointment.

DAY SUPERVISOR

required for 64 bed Tuberculosis Section of
MANITOBA REHABILITATION HOSPITAL
to be appointed November 1st, 1961.
Please apply to:
DIRECTOR OF NURSING SERVICES, SANATORIUM BOARD OF MANITOBA,
1654 PORTAGE AVENUE, WINNIPEG 12, MANITOBA

CANORA UNION HOSPITAL

Canora, Sask.

requires

1. Instructor for Nursing Assistants, duties to commence in December, 1961.
2. General Duty Nurses — for all departments.

For further information, apply to:

DIRECTOR OF NURSING,
CANORA UNION HOSPITAL,
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Now in construction of a new
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School of Nursing - 60 students

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For further information please write to:

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General Duty & Operating Room Nurses for 210-bed General Hospital. Start $335 days, $360 evenings, $355 nights, plus $10 for O.R., university city, 40-hr. wk., 7 holidays, extended vacations, sick leave benefits, free Blue Cross hospital-medical insurance & $2,500 life insurance, retirement program plus Social Security, extensive Intern-Resident Educational Program, living quarters available. Write, Personnel Manager, Virginia Mason Hospital, 1111 Terry Avenue, Seattle 1, Washington.

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Registered Nurses for all services

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Certified Nursing Assistants

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Will afford job opportunities
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Beautifully located on
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Modern Nurses' Residence

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SOUTH PEEL HOSPITAL
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120-bed General Hospital
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General Staff Nurses

for all services including
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Salary schedule
$285 to $315 per month
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Excellent fringe benefits.

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Administrative Supervisor for Obstetrical Department
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Supervisor — Nursing Office — day duty, responsible for in-service program for General Staff Nurses.

Supervisor — for Obstetrical Department.

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Salary according to qualifications: $57.00 - $90.00 per week.
Evening differential: $7.00 per week. — Night differential: $5.00 per week.
Increases: After 6 months, 1 year, 2 years.
Free: Two meals daily — Laundering of uniforms.
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163-bed hospital for a term of nine to twelve months, while present director is on a leave of absence to further her postgraduate studies.

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vacancies for

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Starting salary — $315 to $360 per month, depending on qualifications and experience.

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This is an active treatment mental hospital conducting an approved School of Nursing. 40-hour work week. Civil Service holiday, sick leave and pension program. Good personnel policies. 60 miles from Edmonton.

Apply to Director of Nursing, Provincial Mental Hospital, Ponoka, Alberta, giving qualifications.

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200 Bed General Hospital — Fully Accredited

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Good Salary and Personnel Policies

Allowance for Degree with Experience

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- Salary Schedule — $4,020 to $5,040 per annum • Pension Privileges
- Regular Annual Increments • Liberal Sick Leave with Pay
- Annual Vacation with pay as set out by the Civil Service Commission
- Duties to commence immediately

Qualifications — Instructor with Psychiatric experience preferable

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REGISTERED NURSES AS FLOOR SUPERVISORS

in Geriatric Institution near New York City. Starting salary $4,300 per annum, 37½-hour week plus fringe benefits totalling $700, includes 4 weeks paid vacation, 12 days paid sick leave, 7 paid holidays, Xmas bonus of 1 week's salary. No deduction for meals, residential accommodations $200 year.

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**EXECUTIVE DIRECTOR,
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Superintendent Administrator

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Applications are invited for the position of Superintendent - Administrator of this 40 bed General Hospital operated by the Province of Nova Scotia.

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GENERAL STAFF NURSES

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OPERATING ROOM
MEDICAL
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ST. JOSEPH'S HOSPITAL, HAMILTON

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560-bed hospital — 400-bed expansion program in progress.

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Registered Nurses for General Staff positions.

Excellent personnel policies.

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PORT ARTHUR, ONTARIO**

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and

CERTIFIED NURSING ASSISTANTS

for both an active General Hospital, and a separate chronic and convalescent unit.

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Registered Nurses
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General Duty

40-hour week, excellent salary and personnel policies.

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REGISTERED NURSES
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CERTIFIED NURSING ASSISTANTS

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44-bed hospital with expansion program, 40-hr. wk. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates & personnel policies

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Salary - $300 to $320 per month 40 hour week, no split shifts.

Vacation - 18 days plus 10 statutory holidays a year, 21 days sick leave cumulative from time of employment.

Transportation will be advanced if necessary.

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Opportunities open for
GRADUATE NURSES
in all areas

Liberal personnel policies
Hospital within walking distance of
Wayne State University

Every effort is made to provide the opportunity for each nurse to reach her potential

Must be eligible for registration in the State of Michigan

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REGISTERED NURSES
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Are invited to enquire re: employment opportunities for all departments of new 140-bed hospital. Good personnel policies, O.H.A. Pension Plan.

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BRANDON GENERAL HOSPITAL

now in construction of a new 220-bed modern hospital

Requires:

NURSING INSTRUCTOR
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with postgraduate preparation — duties to commence August 1961.

Apply in writing to:

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Invites application for

GENERAL DUTY NURSES

for Operating Room, Surgical, Medical & Obstetrical Units.

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GRADUATE NURSES

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Modern 110 bed hospital,
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magnificent scenery and
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